Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 3 July 2013

Subject: *Living longer, living better* strategic outline case

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

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Summary

Following the requirements of the Health and Wellbeing Board set out at its meeting on 20 March 2013, seven NHS organisations and the City Council, have prepared a strategic outline case setting out key elements of future arrangements for integrated (better co-ordinated) care for all Manchester citizens.

The strategic outline case details significant progress in areas which are critical to the future development of integrated care, namely the target population, the care models, and the contracting and funding arrangements (part A). It also summarises further work undertaken, and planned, in a range of other important workstreams of the integrated care programme (part B).

Recommendations

In respect of part A, it is recommended that the Health and Wellbeing Board

1. Approve the contents of this document
2. Approve the next steps and timetables set out at A3.1.11, A3.2.7, and A3.3.18

In respect of part B, it is recommended that the Health and Wellbeing Board

3. Note the contents of this document
4. Commit to supporting further work in all the domains included in part B, as set out in the individual chapters
5. To receive a further, detailed, report on progress in September 2013.

Board Priority(s) Addressed:

All

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Background documents (available for public inspection):

'Living Longer and Living Better: An Integrated Care Blueprint for Manchester', report to the Manchester Health and Wellbeing Board, 20 March 2013 (www.manchester.gov.uk/meetings/meeting/1886/health_and_wellbeing_board)

1. Background

1.1. At its meeting on 20 March 2013, the Health and Wellbeing Board approved a 'Blueprint' for *Living longer, living better*, an integrated care arrangements in the city of Manchester. It tasked the eight organisations listed below with creating a strategic outline case for integrated care for Manchester. The eight organisations are:

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

1.2. At its meeting on 24 April 2013, the Executive Health and Wellbeing Group agreed that the priority areas for the strategic outline case to address were

- Understanding the population groups for whom integrated care arrangements were going to be developed
- Understanding the care models (which define what health and social care components should be offered) for the defined population groups
- Understanding how the organisations who will commission, provide and deliver integrated care services in the future will make contracts between themselves, and how money will flow between organisations on the basis of the contracts

1.3. Additionally, it was agreed that work would progress in all the remaining areas ('domains') of the integrated care programme described in the 'Blueprint' but that as significant progress in these domains was dependent on making good progress in the priority domains, more detailed work would be required after approval of this strategic outline case.

1.4. In the two documents accompanying this report, the priority domains are addressed in part A, and the remaining domains together with the majority of the appendices, are addressed in part B.

2.0 Priority domains: population ('Our people')

2.1 The *Blueprint* describes the extension of integrated care services up to 20% of Manchester's population. Following intensive work and review of the thinking behind this proposal, a more radical picture has emerged about how everyone in the city can benefit from better co-ordination of health and social care services. Manchester's population has been categorised into ten sub-groups, each of them with a specific set of needs, aspirations and outcomes. If to these groups are added healthy adults and pregnant women every citizen in Manchester is included. The sub-groups are:

- Adults and children that are at the end of their lives

- Adults and children living with long term conditions, illness, disease or disability and are unwell
- Older people living with dementia and/or are frail elderly
- Adults with chaotic lifestyles such as the homeless, people with long-term mental health problems, people with addictions or those in troubled families
- Children and adults with long-term chronic conditions, illness or significant disabilities but who are generally functioning well.
- Adults and children who are carers
- Older people over 75 who are well
- Children in their early years 0-4
- School and college children who need promotion, information and support to prevent accident and illness
- Adults in work within our organisations who need to change lifestyles, and our perception of how we care, in order to actively deliver and promote living longer living better

2.2 The presentation that accompanies this paper will provide concrete examples of each of these population sub-groups

2.3 This is an important step forward in understanding the needs, aspirations and goals of the whole of Manchester's population, and therefore in providing a basis for designing care models for everyone.

2.4 It will be important, subject to approval of the strategic outline case, to agree quickly which groups are prioritised for the first phase of design and delivery of new care models, and ultimately new services. At the same time, an outline timetable for sequencing the design and agreement of care models, and design of new delivery models, for all remaining population sub-groups will need to be agreed such that dependencies and funding flows are clear and understood from the outset.

3.0 Priority domains: our care models

3.1 Summary care models have been described in the strategic outline case for each of the ten population sub-groups. These care models include the key characteristics needed from the wider health and social care system in the future, and are expected to provide the basis, once worked up in more detail, for what should be the 'care offer' and expected outcomes to the population sub-groups. A partnership of providers would then be expected to design the new delivery models to achieve the care models. This terminology has been used to emphasise that the delivery of care to individuals and population sub-groups is very likely to be the responsibility of a wide range of organisations and individuals including other statutory organisations outside of the current partnership (such as the North West Ambulance Service NHS Trust), non-statutory organisations including the voluntary and community sector, and faith communities, as well as non-health and social care organisations. Carers will be vital parts of the new delivery models for many groups, as well as requiring specific care and support themselves.

3.2 Whilst there is expected to be consistency of care models' approaches and outcomes in Manchester, individual localities will continue to have freedom, for

example in the sequencing of changes to current services, and in arranging the delivery of new services.

3.3 In working through the details of the care models, it has been important to emphasise that the basic meaning of 'integrated care' is not the integration of services or organisations, but improvements in the co-ordination of care as experienced by individual citizens, and population sub-groups. Throughout this report, and the strategic outline case, the central tenet of better co-ordinated care should be borne in mind.

3.3 Once the prioritisation of population sub-groups has been completed, more detailed work can be undertaken on the care and new delivery models for each. It is expected that this more detailed work can be prepared by November 2013

4.0 Priority domains: our contracting and funding

4.1 There is now a wide range of technical options for contracting for health and social care services, and of establishing the funding arrangements underneath those contracts. As part of the development of the strategic outline case, a shortlist of those options which are likely to be most effective in supporting the delivery of integrated care has been created. Further clarity on which of the shortlisted options will be most appropriate for each delivery model can be made following further design work on the prioritised care and delivery models (November 2013).

4.2 It is recognised that further work needs to be undertaken on the financial analysis of the new care and delivery models, exploring their likely affordability, impact on individual organisations, and on the health and social care. It is anticipated that the next phase of this work will commence shortly after approval of the strategic outline case.

4.3 However, it is very clear from the work that has already been undertaken that the commissioning, contracting and funding of future integrated care services will look very different from current arrangements. NHS and local authority Commissioners will need to work much more closely together to agree models of care, and to commission for population groups with diverse needs. Contracts will most likely include risk and benefits sharing arrangements, potentially at significant scale, and will contribute to changing the behaviour of organisations and the whole system towards co-operative, shared goals. Resource investment will shift over time across the health and social care system, towards community, social and primary care services, as the effectiveness of integrated care arrangements is felt; as a result, investment in Manchester's health and social care services will be balanced in a different way from the present.

4.4 Achieving these ambitious goals will in some cases require amendment of even suspension of existing frameworks and regulations. For example, contracts underpinning integrated care arrangements will probably need to be for at least five years in length; and there will need to be flexibility to move away in some cases from the current NHS payment by results regime. Flexibilities and freedoms of these kind are expected to form part of Greater Manchester's expression of interest for 'Pioneer site' status, under HM Government's May 2013 invitation for "local areas to express

an interest in becoming 'pioneers', demonstrating the use of ambitious and innovative approaches to delivering integrated care."

5.0 Other domains

5.1 The remaining domains have been also subject to further work and analysis, and the results of this work are summarised in part B. Part B also, importantly, sets out the next steps for further development for the remaining domains, dependent on approval of the progress described in part A. The domains addressed in part B are:

- How our workforce will need to change
- How our buildings and property can best be used in the future
- What information technology requirements there will be to support co-ordinated care services
- How our health and social care system needs to work together effectively, not only in contractual terms but also in terms of organisational and individual behaviour and the impacts of co-ordinated care on individual organisations and local systems
- How we want the citizens of Manchester to be engaged in helping to design and set up our new co-ordinated care system
- What our co-ordinated care leadership requirements are across the local system
- How the impact and effectiveness of co-ordinated care can be evaluated

5.2 Part B also contains demonstrations of the links between the *Living longer, living better* programme and the Greater Manchester public sector reform programme, and also the links with *Healthier Together*, Greater Manchester's acute reconfiguration programme.

6.0 Stakeholder support

6.1 The strategic outline case has been presented to the Executive Health and Wellbeing Group, and the joint integrated care boards of north, central and south Manchester. All of these groups have approved the contents of the documents, and supported their recommendations.

7.0 Recommendations

7.1 In part, at the end of each domain, there is a list of actions to be taken following approval from the Health and Wellbeing Board. A summary of these actions is as follows:

For the 'our people' domain the key actions are

- To complete further activity and cost analysis, including analysis of the baseline cost of existing service models, by September 2013; this information will be used to support work on new contracting and funding arrangements by March 2014.

For the 'our care model' domain the key actions are:

- To have prepared care and delivery models for each population sub-group by November 2013, for agreement by commissioners in December 2013.

- To have agreed, between partnerships of providers at city-wide or locality level, new delivery models for each prioritised sub-group by April 2014

For the 'our funding and contracting' domain the key actions are:

- To agree across the health and social care system high-level principles governing the way in which organisations will work together

- To continue the work on developing contracting and funding options, with the expectation of establishing new contracting models from 2014/15

7.2 Full details of each set of actions are contained within part A, at A3.1.11, A3.2.7, and A3.3.18.

7.3 Additionally, the eight organisations involved in *Living longer, living better* intend to recruit a leader for the next phases of the programme. This new post will work closely with the existing governance structure, and will be supported by a city-wide programme management office which will help monitor and evaluate progress.

8. Conclusion

8.1 The strategic outline case work to date marks significant progress in jointly defining key elements of radical future change to Manchester's health and social care system, and sets out the next steps to be taken, at pace, amongst the eight NHS and local authority organisations to create a comprehensive system, involving both a wide range of organisations, and potentially every citizen as an individual, enabling everyone to live longer, and live better.

LIVING LONGER, LIVING BETTER

STRATEGIC OUTLINE CASE

PART A

June 2013

Foreword

Manchester is a proud, thriving and dynamic city. Working together, the City Council and the local NHS are determined that Manchester's people enjoy long, healthy and fulfilling lives.

To help us achieve this, we need a radical change in the way health and social care services are offered in the city. We need a much stronger emphasis on helping people stay well and, when they do have an illness or long-term health condition, receiving the best quality care at home or in the community. We need a new culture amongst our professionals, our managers and leaders, and our citizens. And we need new ways of using our financial resources so we can collectively achieve the best for our population.

This document describes the latest stage of our thinking and planning for the programme of changes we have called *Living longer, living better*. I commend it to you, and believe that it makes the next stage on our vitally important journey towards transforming our health and social care services in the city.

Sir Howard Bernstein
Chair, Executive Health and Well-being Group
Chief Executive, Manchester City Council

Contents

Living longer, living better strategic outline case

A1 Executive summary

At a glance …

In this document we:

- ***Describe in detail the sub-groups of people in Manchester's population for whom we want to provide new care arrangements***

- ***Describe the characteristics needed for the care models for our population***

- ***Describe what formal arrangements we can put in place between our organisations to support our new care arrangements***

Introduction

NHS organisations in Manchester together with the City Council were asked by the Health and Well-being Board in March 2013 to prepare a 'strategic outline case' to test the idea of extending the coverage of the city's 'integrated care' arrangements from about 2% of the population to 20%. This request was made following approval of a '*Blueprint*' for integrated care in the city.

'Integrated care' refers to advanced arrangements for organisations, teams and professionals working together to provide high quality co-ordinated care to individuals and families usually in their own homes or in the community. Integrated care arrangements are intended to put people in control of their own care, and to reduce avoidable use of hospital and other services, especially emergency services. Manchester's plans for integrated care are known as the '*Living longer, living better*' programme.

A 'strategic outline case' is a document which sets out the detail of key parts of a future plan, and tests the underlying assumptions behind a planned change; in this case in health and social care services.

Our three priority areas

The leaders of Manchester NHS organisations and the City Council agreed to use the strategic outline case to describe in more detail three main areas or 'domains' of the city's plans for integrated care. These three domains are: our people (the city's population), our care model (the characteristics of co-

ordinated care services) and our contracting and funding arrangements. Real progress has been made in all three of these domains. This progress has been described in part A of the strategic outline case (this document). Part B contains information about the work we have been doing in other important domains such as our workforce and buildings. Part B has its own executive summary.

Our people

The *Living longer, living better Blueprint* gave some information about the 20% of Manchester's population to which integrated care arrangements are expected to apply in the future. The information there mainly concerned the risk different groups of people within that 20% have in terms of admission to hospital. We were able to categorise 20% of our population into either low, moderate, high or very high risk groups. Whilst useful, this did not provide enough detail about the needs and characteristics of our population to help us design future services.

In this strategic outline case, we have been able to provide much more detail about the population for whom we initially want to focus our integrated care arrangements. Exploring this detail has changed our thinking on the population we want to focus our integrated care arrangements on in the first instance. We have identified ten sub-groups of people within our whole population (i.e., not just 20%) where we think our service 'offer' (what services are available to individuals and groups) needs to change and develop. If to these groups are added healthy adults and pregnant women every citizen in Manchester is included. These ten groups are:

Very high and high risk sub-groups

- Adults and children that are at the end of their lives
- Adults and children living withlong-term conditions, illness, disease or disability and are unwell
- Older people living with dementia and/or are frail elderly
- Adults with chaotic lifestyles such as the homeless, people with long-term mental health problems, people with addictions or those in troubled families

Moderate risk sub-group

- Children and adults with long-term chronic conditions, illness or significant disabilities but who are generally functioning well.

Low risk sub-group

- Adults and children who are carers
- Older people over 75 who are well
- Children in their early years 0-4
- School and college children who need promotion, information and support to prevent accident and illness

- Adults in work within our organisations who need to change lifestyles, and our perception of how we care, in order to actively deliver and promote living longer living better

We have also been able to assess some of the changes to people's lives which lead them to move from a lower to a higher risk group, in terms of their likelihood of hospital admission. Additionally, we have been able to analyse some of the ways in which the different groups listed above use health and social care services, and how much these services cost. We know that we need to do more work in this last area of cost, and one of the immediate tasks after the approval of this strategic outline case will be to commission some technical help to enable us to understand the costs of services to these groups better still.

In completing this new work on our people, we have also acknowledged the implication that over time our integrated care arrangements will expand to cover everyone who lives in Manchester, helping everyone live longer and live better. One of our immediate tasks now is to agree how we prioritise changes to services for the ten groups of people we have identified, and over what timescale.

Our care models

Now that we have a much clearer understanding of the different groups of people who make up our target population, we have been able to make real progress on describing key characteristics of our care models for the priority groups – in other words, describing features that will need to be seen in future new delivery models.

The care models will emphasise the need to tailor models of care to specific population groups and their needs. Components will include co-ordination of care around individuals and families and the ability to plan and manage one's own care The care models will also emphasise prevention and support to reduce the risk of developing long-term illnesses; from being in crisis; and preventing accident and injury that have a major destabilising impact on people's lives. For everyone, there will be an emphasis on keeping well, and healthy.

The care models that are proposed will be based on who people are, why they are a priority, the components of care that are needed and the success by which we will measure outcomes. These models will work if there is a partnership between commissioners in agreeing the care models and a partnership between providers in developing new delivery models, which co-ordinate care to deliver the care model and achieve the outcomes.

The new delivery models will be specific to population groups and organisational configurations so that each area will need to respond to the care models that have been put forward. The implementation plan that will be developed in response to the care models will need to be implemented at

scale and pace, with an explicit agreement from commissioners and providers to shift resources to make new delivery models sustainable.

Our contracting and funding arrangements

Our contracting and funding arrangements have also been described in much more detail than previously. We recognise the importance of contracting and funding arrangements between organisations in order to help support the delivery of integrated care in the future. Although lots of things influence the ways in which organisations operate and behave, contracts and funding arrangements play a major role, so finding the right sorts of arrangements is very important.

In our work in this area we have been able to explore a wide range of options for contracting and funding, and we have been able to draw up a shortlist of contract options, and provide some indications of how we think funding arrangements should best be made. We will be able to say exactly what kind of contract, and which kind of funding arrangements, will apply when we have completed the next stage of work on our care model. But we have already achieved an important degree of consensus on what we think will work in Manchester.

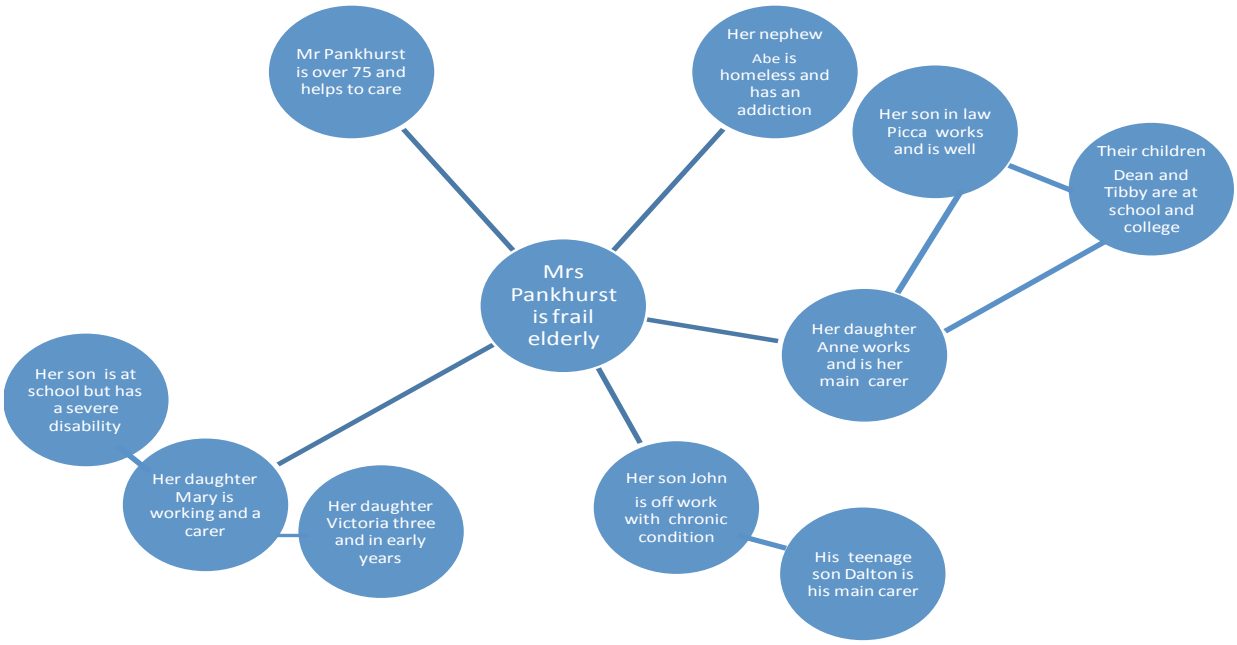
Conclusion

Taken together, we believe that the strategic outline case represents excellent progress in preparing our plans to help Manchester people live longer and live better. It will not be a simple task to achieve our ambitions, and we will need excellent leadership at every level within our health and social care system (described further in part B). But we are confident that we can build on a progress over the coming months, and start to implement the transformation we have described.

The "Pankhurst" family

The *Living longer, living better Blueprint* introduced "Mrs Pankhurst". If we deliver *Living longer, living better,* we believe the future for our family will be different.

Meet the "Pankhursts" in 2013



The future: 2020

"Mrs Pankhurst" has 24/7 co-ordinated care, with a named worker who can wrap services around her as an individual. She has one urgent care number to ring at any time of the day knowing that she will be known through her care plan, listened to, triaged and given appropriate care in a 4-hour period 24/7 in her home, community facility or if needed hospital. "Mrs Pankhurst" uses equipment to support her daily living (the environment design enables her and reduces the need for physical support) and is able to speak to the team via Skype or video calls.

"Mrs Pankhurst" feels cared for, she is treated with dignity and given information and care to meet her personal concerns and goals which will include decreasing her pain, increasing her comfort and environment at home and giving her support and choice about how to live the remainder of her life with dignity.

"Mrs Pankhurst's" daughter "Anne" will be offered co-ordinated support and information to enable her not only to care for her mother appropriately but to carry on working and caring for the rest of her family including her school aged children. "Anne" feels well and able to cope.

"Anne's" children are knowledgeable about their life styles and their life choices and inspired to live healthy and productive lives. They use technology and services in the community appropriately to self-manage any short-term illness and are aware of risks of accidents and illness through addiction. They have first aid skills to manage most minor injuries.

"Picca" is working within one of the new delivery models in the city and is an advocate for caring differently and being able to inspire people to live more healthily, he is volunteering at a local sports centre to coach a youth team.

"Mr Pankhurst" has regular screening and health checks. He is supported to enable him to remain well and living independently in the community. He is sharing "Mrs Pankhurst's" care with "Anne" and is involved in her future care planning.

"John" is at work and self-managing his long-term conditions of chronic obstructive pulmonary disease and diabetes. He has a clear and owned care plan and has learnt how to use technology to enable him to manage his condition with knowledge. He has information about the new delivery model, and feels that, when he needs it, it is responsive to his needs with regular checks and care planning.

"Dalton", his son, is no longer losing days at school in order to care for "John" and is able to have time to do his homework and socialise with friends. He is now projected to achieve good grades in his GCSEs.

"Mary" is able to work and care for both her children, "Victoria" has had a co-ordinated programme of screening, immunisation and care in her early years and is now ready for school with the potential to do well. Her son has a shared care plan that "Mary" understands and a co-ordinated package which enables him to attend school and be cared for at home when he needs extra support.

"Abe" is now in accommodation and has been supported to get a part time job; his health has improved through a co-ordinated package of care. He is knowledgeable about where to go and how to manage his addiction and illnesses when necessary.

Living longer, living better strategic outline case

Part A

A2. Introduction and background

A2.1 Introduction

NHS organisations and the City Council in Manchester have been formally working together to integrate health and social care services since 2010. 'Integration' has been adopted as a tool to achieve the following goals:

- Enabling Manchester people to live longer, and live better – the title now given to the integration work programme
- Enabling patients and users of health and social care services to experience care which is 'planned with people who work together to understand me and my carers, put me in control, co-ordinate and deliver services to achieve my best outcomes' – a definition of integrated care developed by National Voices, a national coalition of health and social care charities in England
- Enabling financial and other resources to be moved around the health and social care system to avoid unnecessary costs, and to promote efficiency

As such, integration is a means to several ends in Manchester: better health, longer lives, better care and better use of money, skills and buildings.

Integration itself has been pragmatically defined across Manchester as the co-operation required between health and social care services, at every level within the local care system, to build and develop services in the community. One of the areas of work has been to reduce avoidable demand for hospital admissions and treatment and to reduce admissions to residential and nursing homes for people with long-term conditions. When we use the term 'integration' in this strategic outline case, we include the expectation that services will be more effectively co-ordinated: this is a major issue for both our population, and our workforce.

Within Manchester, the three localities of North, Central and South, have developed their own approaches to integration including their own services, tailored to the specific needs of their population, their own planning and governance arrangements, and of course their own relationships and local system cultures.

A2.2 The *Blueprint*

In 2010, formal planning started to transfer the community health services then managed by NHS Manchester to Manchester's three acute hospital trusts, Manchester Mental Health and Social Care Trust and the City Council. This transfer, which took place in April 2011 as part of the implementation of the *Transforming Community Services* policy (Department of Health, 2009), provided an important platform for the subsequent development of integrated care in the city.

Also in 2010, as local NHS organisations and the City Council agreed to prioritise urgent care for transformational change, and a programme initiation document was prepared. This document laid a further foundation for current work on service integration, and, like *Living longer, living better*, was based on the principle of local leadership for design and delivery.

Since the transfer, the eight major health and social care organisations in the city have worked closely together to optimise the benefits for patients, and to maximise the efficient use of money, staff and buildings which the new arrangements allowed. New services which aim to support the goals of reducing hospital, residential and nursing home admissions and to improve care for people with long-term conditions have been launched, and careful planning has been undertaken for future services across the city.

This partnership work reached another critical milestone in early 2013 when the eight organisations which are party to the *Living longer, living better* integrated care programme developed a *Blueprint* document which was approved by the Health and Well-being Board at its 20 March 2013 meeting. This *Blueprint* formally launched the *Living longer, living better* programme – a complex series of changes to Manchester's health and social care system, with implications stretching more widely that health and social care alone, which is being collectively managed as a single portfolio of projects.

The *Blueprint* confirmed the goals of the integrated care programme, and outlined plans significantly to increase the scale and pace of integrated care developments with the potential at that stage to provide coverage to a fifth of Manchester's population. In accepting the *Blueprint*, the Health and Well-being Board requested that the *Living longer, living better* programme move ahead to prepare a strategic outline case for the scale-up of integrated care across the city.

A2.3 The strategic outline case

The challenge to scale up integrated care arrangements in Manchester to provide services to up a fifth of the population emerged from a modelling study commissioned by the Health and Wellbeing Board which was reported in November 2012. Coverage of existing integrated care arrangements in population terms is estimated at approximately 2%. The proposal that our integrated care arrangements are extended to cover a further 18% of the population needs to be tested and the needs and characteristics of the people

for whom new or enhanced services are to be made available needs to be better known. *Knowing our target population better is the first goal of this strategic outline case.*

Once the target population has been understood better, more work can be undertaken on the types of services – the service model - that will meet the needs of people within the target population. Matching the design of integrated care services to the varied needs of the population, and outlining the main steps that would need to be taken to move from current arrangements to scaled-up arrangements, is critical. *Understanding our care model better is the second goal of this strategic outline case*.

Greater clarity on the population and services to people in the population are important dimensions to a third critical area for the *Living longer, living better* programme: the formal business (contractual) arrangements that need to be put into place between organisations. In the future, money will need to move within the health and social care system from its current pattern of investment to a new pattern, with higher levels of resource available for integrated care and correspondingly less for hospital services. This changed pattern of investment needs to create incentives for organisations to achieve the programme goals. But the shift has to be achieved whilst maintaining quality and safety of care. As such, the integrated care programme in Manchester belongs in the context of the wider Greater Manchester reform programme, more details of which can be found at appendix B4. Finally, the work on contractual arrangements needs to reflect the principles of public sector reform in Manchester.

So understanding the principles, high-level terms and conditions, and the options for technical contractual frameworks under which resource flows will change in the future, are essential to the future of integrated care in Manchester. *The third goal of this strategic outline case is to set out proposals for our contractual arrangements that will support the scale-up of integrated care in the city*.

Part A of the strategic outline case addresses these three priority goals. Part B, a separate document, considers the implications arising from these priority areas for every other aspect – or 'domain' - of the *Living longer, living better* programme:

- How our workforce will need to change
- How our buildings and property can best be used in the future
- What information technology requirements there will be to support co-ordinated care services
- How our health and social care system needs to work together effectively, not only in contractual terms but also in terms of organisational and individual behaviour and the impacts of co-ordinated care on individual organisations and local systems
- How everyone affected by co-ordinated care arrangements and the system change that results from them can be engaged in helping make it work

- What our co-ordinated care leadership requirements are across the local system
- How the impact and effectiveness of co-ordinated care can be evaluated

Part B addresses the final goal of this strategic outline case which is to summarise the key implications for these areas (known as 'domains') arising from the work on our population, service model and contractual arrangements.

A2.4 Further background

Further background on the *Living longer, living better* programme and its eight domains can be found in the *Blueprint*. Details of the organisations involved in the programme and the governance arrangements under which this strategic outline case was developed, can be found in part B, appendices B1 and B2. A particularly important appendix is the summary of the evidence base for integrated care, referred to in the executive summary: this is found at Appendix A1.

A3 The key domains

A3.1 Our people

Blueprint statement

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

A3.1.1 Background

Early work on integrated care in the three Manchester localities focused on those patients who were most at risk of unplanned hospital admission: the top 2% of the population. The review of Manchester's progress in Autumn 2012 on behalf of the Manchester shadow Health and Wellbeing Board concluded that the city was not ambitious enough in its aspirations for integrated care and that the city should focus on the 20% of patients most at risk of unplanned hospital admission.

For the *Blueprint* document, we sub-divided the population of patients registered with GP practices in the city (c. 540,000 people) into low, moderate, high and very high risk of admission using a risk stratification tool known as the Combined Predictive Model (CPM). The result of this analysis is shown in the diagram below:

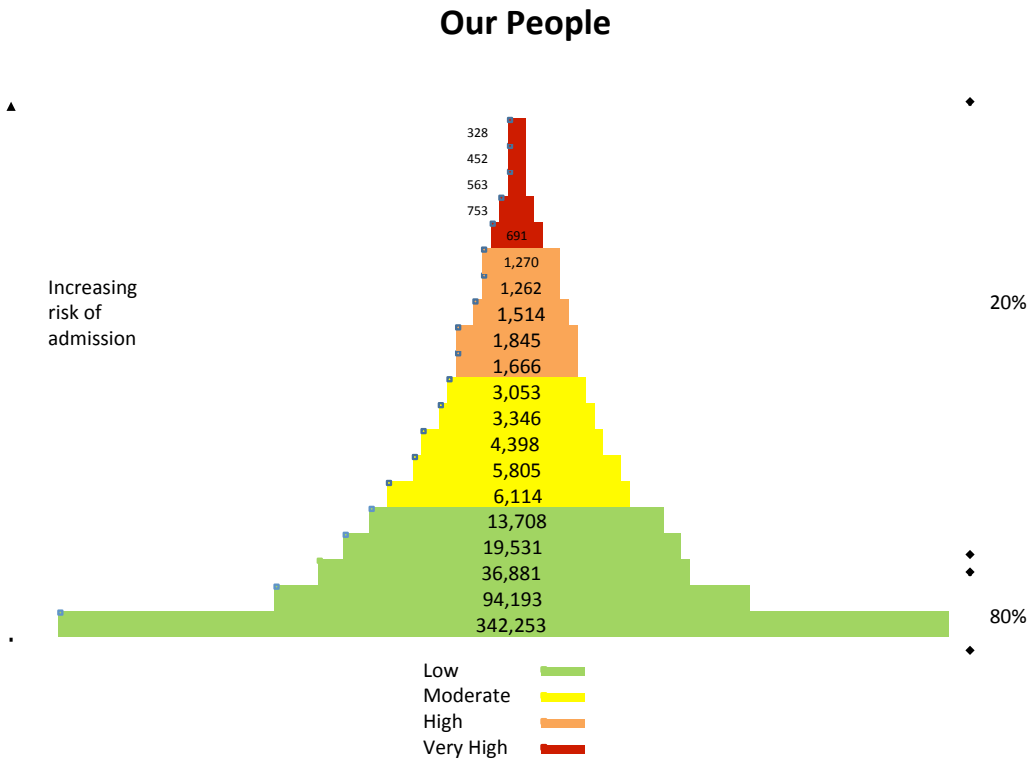


Figure 1, stratified risk pyramid for Manchester's population

Two key points emerged from this analysis:

- Expanding the current integrated care programme to include the 20% of patients at the highest risk of admission (as recommended by the McKinsey report) would draw in people classed by the CPM as being at low or moderate risk of admission, as well as those at high or very high risk, with the number at low risk being much greater than the number at high or very high risk. Given the broad range of patients and risk levels within the 20% it is likely that a variety of care models will be needed to meet the differing needs of the population sub-groups.

- The progression from low through to moderate, high and very high risk of admission is not a smooth one and there is clear evidence of the existence of steps between each risk category (e.g., between low and moderate risk and between moderate and high risk of admission etc.)

Following the endorsement of the *Living longer, living better Blueprint*, it was agreed that the objectives of the 'our people' domain should be to:

- Gain a more thorough understanding of the city's population and its needs
- Test whether the top 20% at risk patients should form the focus for the city's integrated care models
- Identify population segments for care interventions
- Identify the costs of the current care models

- Support cost benefit analysis of the new care models
- Begin the development of a methodology to predict the future direction and shape of the risk cohorts

A3.1.2 Findings of data analysis undertaken for the strategic outline case

For the strategic outline case we have carried out some further analysis of the population at risk of admission using the Combined Predictive Model (CPM) risk stratification tool.

An individual risk of hospital admission score is derived for each patient through the use of an algorithm using acute hospital activity (planned and unplanned) and GP practice disease registers, ranging from 0, the lowest level of risk to a maximum of 100, the highest level of risk. Patients are then grouped together into risk cohorts as follows:

- Risk score 0-25 – low risk
- Risk score 26-50 – moderate risk
- Risk score 51-75 – high risk
- Risk score 76-100 – very high risk

The data includes all patients registered with a Manchester GP and therefore includes patients who do not live in Manchester. Although the number of non-Manchester residents is relatively large, c. 50,000, their distribution among the risk cohorts is broadly similar to Manchester residents although the proportion of high and very risk patients is smaller for non-residents than residents.

The CPM risk stratification tool has limitations in its usefulness for identifying population needs for new integrated care models. It doesn't include data from a range of services that will impact upon people's risk of hospital admission, for example; prescribing, community services and social care, nor does it predict people's risk of admission to social care. However, much of the required data isn't readily available and there have been challenges relating to data sharing where some of the data was available. Mental health trust activity data was available but not costs.

For social care, the spend on residential and nursing care at the end of 2012/13 was £24,079k; spend for homecare in the same period was £10,126k; for re-ablement, the spend was £4,696k[1]. For 2013/14, the City Council's budget for residential and nursing care has been increased by £493k to reflect increased cost in this area.

The value of Manchester CCGs' contract with Manchester Mental Health and Social Care Trust for 2013/14 is £64,000k.

The difficulty in obtaining activity and cost data has meant that the analytical team has been unable to undertake all the data analysis required to support the agreed objectives for the domain.

A3.1.3 Outputs from data analysis

Each risk cohort includes patients of all ages, but the age distribution varies between the cohorts. The population distribution of the low risk cohort echoes that of the population as a whole, whereas for the high and very high risk groups tend to include a larger proportion of patients in older age groups.

Key characteristics of the different risk cohorts

Using the data behind the risk stratification scores, we have been able to derive a picture of some of the key characteristics of the different risk cohorts. Key facts for each cohort are as follows (abbreviations are explained in appendix A2):

Low risk

- 94.5% of total population
- Average age 34
- 88.7% not on a GP practice disease register
- Top disease register hypertension (2.3% of cohort)

Moderate risk

- 4% of total population
- Average age 55
- 43.4% on no GP disease register
- 10% on 4+ GP disease registers
- 30.5% on hypertension register
- 14.2% on diabetes register
- 13.2% on cardiovascular disease register
- 8.8% on chronic obstructive pulmonary disease register

High risk

- 1.2% of population
- Average age 64
- 27.6% on no GP disease register
- 17.8% on 4+ GP disease registers
- 35.1% on hypertension register
- 17.6% on diabetes register
- 18.9% on cardiovascular disease register
- 15.2% on chronic kidney disease register
- 13.9% on chronic obstructive pulmonary disease register

Very high risk

- 0.3% of population
- Average age 65
- 19.9% not on GP disease register

- 22.4% on 4+ GP disease registers
- 35.8% on hypertension register
- 19.3% on diabetes register
- 22.1% on cardiovascular disease register
- 18.4% on chronic kidney disease register
- 18.8% on chronic obstructive pulmonary disease register

There are some similarities between patients in the different risk cohorts, particularly the disease register characteristics of the high and very high risk patients. The notable exception is chronic obstructive pulmonary disease where the proportion of very high risk patients with this disease is markedly higher than for high risk patients.

The significant proportion of high and very high risk patients not on a disease register may be for a number of reasons:

- Under-ascertainment of long-term conditions in primary care - There are differences between observed and expected rates of disease which can reflect variation in diagnosis and data recording in GP practices.

- Accuracy of diagnosis - further analysis was undertaken of the 19.9% of patients not on a GP disease register who were in the very high risk cohort. The largest group within this group were children who had been admitted with asthma/wheeze or other respiratory problems. This reflects difficulties in accurately diagnosing asthma in young children, although it is possible for them to be included within a register for wheeze rather than definitively for asthma.

- There are further limitations in GP disease registers with some factors that are known to increase the risk of hospital admission, for example frailty, to not be associated with a particular disease. There are tools to assess frailty and it would be possible to develop a register for frailty.

- Patients not on disease registers are likely to include those with “chaotic” lifestyles e.g., homelessness or addiction who may not be engaged in routine primary carelong-term conditions management. This may be supported by the finding that mental health community contacts, inpatient bed days and outpatient appointments were all higher among high and very risk patients not on disease registers were all higher than for those on disease registers. When analysing the numbers of high and very high risk patients not on disease registers by GP practice, there was considerable variation between practice numbers with higher numbers in practices that are likely to have more patients with such “chaotic” lifestyles e.g., Urban Village which has a large number of homeless patients registered at the practice

A3.1.4 Activity and costs

Analysis of the data has shown that there are marked differences in the activity associated with high and very high risk patients who are or are not on disease registers. For those on disease registers, there were higher levels of planned care whereas, for those not on disease registers, there were higher levels of urgent care activity.

Risk cohort	Emergency activity costs in last 12 months	% of total emergency costs in last 12 months	Average emergency activity cost per patient	Planned activity costs in last 12 months	% of total planned activity costs in last 12 months	Average planned care activity cost per patient
Very high	£13,344,743	13.2	£7,260	£3,284,650	2.7	£1,787
High	£19,892,883	19.7	£3,020	£10,859,929	8.9	£1,648
Moderate	£25,656,593	25.4	£1,200	£27,484,687	22.4	£1,286
Low	£42,090,779	41.7	£82	£81,048,930	66.1	£159

Table 1, emergency and planned care costs by risk cohort

The data in the table above demonstrate the cost and activity associated with the highest risk patients relates to urgent care, indeed when adding together the costs for the 5.5% of the population that are in the very high, high and moderate risk cohorts, they account for 58.3% of the total urgent care costs. In order to reduce this urgent care cost and activity, it is essential that new service models are able to manage patients proactively and so prevent urgent activity.

A3.1.5 A new approach to understanding our population

Patients within each risk cohort are mixed; for example children appear in all risk cohorts, as do older adults. We need to be clearer about which groups we want to target when developing effective interventions to prevent an increase in patients' risk of hospital admission and enable the population to live longer and live better. In some cases, the target group will be one that crosses over different risk cohorts (e.g., children, older adults etc.) but in other cases we will need to target specific groups within a particular cohort of risk. This means that segmenting the population into the four cohorts of very high, high, moderate and low risk is too simplistic and that we need to understand the population groups within and across those risk cohorts.

For example, when analysing CPM data relating to the 26,296 people aged over 75, although numbers in the higher risk bands were higher than for the population as a whole (very high 2.4% compared to 0.3% for the population as a whole; high 8.5% compared to 1.2% of the population as a whole; moderate 20.7% compared to 4.0% of the population as a whole), there are still 17,965 people (68.3%) aged over 75 who are scored as low risk. This includes 8,675 (33.0%) who are not on any long-term condition register. Of

those over 75s on disease registers, the most common conditions were hypertension (51.2% of over 75s, 8.9% for the population as a whole), chronic kidney disease (21.6% of over 75s, 1.7% for the population as a whole) and cardiovascular disease (18.2% of over 75s, 2.3% for the population as a whole). This shows that although long-term conditions are much more common among older people future care models need to reflect the fact that many older people do not have long-term conditions.

The risk stratification algorithm weights previous hospital activity as a higher predictor or risk of future admission that data relating to disease registers. This means that the risk stratification tool, although useful, may not predict people before their first admission. It was also felt to be important to gain an understanding of what the characteristics of cohort groups are and to understand the extent and causes of movement between risk cohorts.

With this in mind, we have undertaken a programme of data analysis to help us understand the characteristics of each cohort group and to understand the extent and causes of movement between risk cohorts. In undertaking this analysis, we have adopted the concept of "stock" and "flow" used as part of the public service reform work across Greater Manchester and, more locally, as part of the work with Troubled Families in Manchester. Broadly speaking, "stock" refers to those individuals with an *existing* condition (or set of conditions) whereas the "flow" refers to those individuals whose characteristics place them *at risk* of having these conditions in the future. In terms of our work around integrated care, the "stock" for our population is those at high and very high risk of admission, the "flow" being those at low and moderate risk who may become high and very high risk in the future.

Drawing on the stocks and flows approach, we have sought to identify the key characteristics or triggers that lead to an increase in an individual's risk of hospital admission and therefore to develop care models that work with both those at the highest risk levels ("stock") as well as those at lower risk levels to ensure their risk of admission does not increase ("flows"). For each care model, we will need to understand the "stocks and flows" within that care model's population and the extent to which "stocks" in one care model may be the "flow" for another.

Our analysis has been underpinned by three further pieces of work that have been undertaken to try and determine what those characteristics are:

- Literature search
- Use of the *Living longer, living better* reference group to obtain specialist clinical opinion and experience
- Further data analysis

A3.1.6 Literature search

Research evidence on the characteristics that cause hospital admission is relatively limited and tends to focus on medical factors rather than social

causes. There has been recent evidence about the effect of social isolation, particularly among older people[2].

The Nuffield Trust undertook a feasibility study[3] to predict which patients would experience an increase in higher cost social care found that significant predictor variables included:

- Age, especially people aged 85 and over
- Female gender
- Previous social care use
- Previous emergency health activity

There may be some association between these variables and a person's increasing risk of hospital admission.

A3.1.7 *Living longer, living better* reference group

The *Living longer, living better* reference group discussed risk characteristics at its meeting on 30 April 2013 and identified the following as the main triggers for hospital admission:

- Aged 75+
- Living alone
- In receipt of care for personal and social care needs
- No family support
- Impact of the time of day/day of the week
- Carer breakdown

A3.1.8 Further data analysis

Data analysis was undertaken on the movement of patients across risk stratification cohorts over time. Analysis was undertaken at two points in time, May 2012 and May 2013. Although there will inevitably some "churn" in the population owing to natural change (e.g., births, deaths) and migration into and out of the area, around 89% of patients were present at both points in time. Of the patients present at both dates, 94% remained within the same risk band, 4% experienced a reduction in their risk score and 2% experienced an increase in their risk score. The greater number reducing their risk score rather than increasing may reflect deaths among patients who would therefore be included as "churn".

Further analysis was undertaken on the 992 patients whose risk score increased from low to high or very high. The analysis suggested that 7% of the patients were likely to be living in a communal establishment, mainly a nursing or residential care home. Patients lived across 326 different lower layer super output areas (LSOAs), but there were only four with more than 10 patients (in the wards of Woodhouse Park, Bradford, Gorton North and Cheetham).

As NHS data we used does not contain information about the socio-economic circumstances of patients, data from the Mosaic geo-demographic classification tool was used to provide some further insights into the characteristics of the patients experiencing a substantial increase in their risk score over the last 12 months. The most common Mosaic group among the 992 patients was Group O ("Families in low rise social housing with high levels of benefit needs). 29% of patients were in this cohort, compared to 22% for the population as a whole. Mosaic Group O is more likely to have the following demographic and lifestyle characteristics:

- Be lone parents with younger dependent children or live in households with dependent children, including those where there are none in employment
- Be living alone (separated, divorced or widowed)
- Live in more deprived areas
- Live in semi-detached or terraced social housing and institutional properties
- Live in lower value and poorer quality housing (e.g., with condensation, vandalism or crime)
- To be claiming a range of benefits, unemployed or longer-term sick
- To have a lower income and find it difficult or very difficult to cope on this

In terms of use of services and health related behaviours*, people classed as being closely linked to this Mosaic Group are more likely than the average person to:

- Experience poor/poor general health or be permanently sick
- Be admitted to hospital for chronic lower respiratory diseases (including chronic obstructive pulmonary disease), other acute lower respiratory infections, obesity and diabetes
- Suffer from anxiety and depression and from health problems related to alcohol or drugs and epilepsy
- Be a current (and heavy) smoker, consuming more than 20 cigarettes a day
- Spend money on alcoholic drink, tobacco and narcotics

* based on data from HES, 2011 Census and other national surveys such as the British Household Panel Survey (BHPS) and Health Survey for England (HSE)

A3.1.8 Implications of not changing current service models

A simple projection of the changing shape of the risk profile for the city was undertaken.

Table 2: Adjusted projections of population risk levels 2013-2021 (non-age weighted)

Year	Low Risk	Moderate Risk	High Risk	Very High Risk	Total
2013	510,554	21,374	6,588	1,838	540,354
2014	514,071	21,521	6,633	1,851	544,076
2015	517,359	21,659	6,676	1,862	547,556
2016	520,428	21,787	6,715	1,874	550,804
2017	523,139	21,901	6,750	1,883	553,674
2018	525,631	22,005	6,783	1,892	556,311
2019	527,858	22,098	6,811	1,900	558,668
2020	529,879	22,183	6,837	1,908	560,807
2021	531,726	22,260	6,861	1,914	562,762

The figures included in the above table are based on the simple application of growth rates drawn from the ONS 2011-based Sub-national Population Projections to the current risk profile of Manchester. At this stage, it does not take in to account either differential growth rates among different age groups or any changes in disease prevalence and hospital activity that might affect the distribution of risk across the population. Further work is needed to adjust the projections to take these and other factors into account.

A3.1.9 Population impact on the care model

The *Living longer, living better Blueprint* approach to integrated care focused on the characteristics of “Mrs Pankhurst”. Further work since has identified the need to take a more sophisticated approach and to acknowledge that there are many different segments within the low, moderate and high/very high risk groups and that it would therefore be necessary to develop a range of care models for those different segments. The proposal to increase the proportion of the at risk population covered by the city’s integrated care to 20% may be too simplistic and not effectively cover the approach needed to meet the needs of different population segments. It is therefore proposed that different integrated care models need to be developed to meet the needs of 100% of the city’s population, however this should be undertaken over a period of time, with the following identified as priority segments[4] to develop integrated care models for:

High and very high risk segments

- Adults and children that are at the end of their lives
- Adults and children living withlong-term conditions, illness, disease or disability and are unwell
- Older people living with dementia and/or are frail elderly
- Adults with chaotic lifestyles such as the homeless, people with long-term mental health problems, people with addictions or those in troubled families

Moderate risk segments

- Children and adults with long-term chronic conditions, illness or significant disabilities but who are generally functioning well.

Low risk segments

- Adults and children who are carers
- Older people over 75 who are well
- Children in their early years 0-4
- School and college children who need promotion to prevent accident and illness
- Adults in work within our organisations who need to change the way they care

Rather than use the term 'segment' we will use the term 'sub-group' from now on in this strategic outline case.

A3.1.10 Meeting the *Blueprint* objectives

As outlined at the start of the chapter, the objectives for the Our People domain were to:

- Gain a more thorough understanding of the city's population and its needs
- Test whether the top 20% at risk patients should form the focus for the city's integrated care models
- Identify population sub-groups for care interventions
- Identify the costs of the current care models
- Support cost benefit analysis of the new care models
- Begin the development of a methodology to predict the future direction and shape of the risk cohorts

Through the analysis undertaken and the outputs of care model domain, some of these objectives have been met:

- There is now a greater understanding of the city's population and their care needs
- It is not felt appropriate to simply increase the scope of integrated care models to cover the 20% patients most at risk
- We have identified 10 priority sub-groups
- We have started to scope out the analysis needed to support the work around further development of the 10 priority sub-groups
- We have incomplete costs of current models
- We are not yet able to begin cost benefit analysis of new care models as those models are not yet developed to a sufficient level of detail
- We don't yet have a comprehensive methodology to predict the future direction and shape of the risk cohorts

A3.1.11 Next steps

During the development of this strategic outline case, it was become evident that the 'our people' and 'our care model' domains are closely linked and will require continued close working to determine how care models reflect population needs.

Priority actions for the 'our people' domain will be:

By September 2013 – Complete further analysis of cost and activity of those elements of current service models that were unable to be analysed to date. This may need to include the use of proxy data e.g., from other locations, owing to the continuing challenges of obtaining all the necessary data items.

By September 2013 – Undertake further work to understand the activity and cost implications of maintaining current service models

By March 2014 – Assess the use of the current risk stratification tool, the Combined Predictive Model. The current risk stratification tool predicts the risk of hospital admission. There have been models developed for social care (outlined in the Nuffield Trust report: *Predicting social care costs: a feasibility study* (London: Nuffield Trust, 2011)) although they are not in widespread use. It may therefore prove useful to either cross refer the CPM risk stratification data with a model for social care, or for the city to develop a model which predicts the risk of both hospital and social care costs.

For the purposes of the analysis undertaken for this strategic outline case, movement of patients across risk cohorts in the risk stratification tool was measured between two data points (May 2012 and May 2013). It will be possible to track changes over time on a month by month basis as the tool is re-run each month. Such changes over time could then inform models for predicting the shape and size of risk cohorts in the future.

By March 2014 to support the work of the 'our contracting and funding' domain to agree a methodology to identify cost benefit analyses for the new care models.

A3 The key domains

A3.2 Our care 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."

A3.2.1 Background

This chapter describes a population and partnership approach to commissioning and delivering new models of care. We have undertaken four workshops with colleagues from the eight organisations, and have fed into the chapter the thinking from various organisations and seminars on integrated working. In doing so we have concluded that care models should focus on:

People: To create a city where the population lives longer and lives better, with individuals, families and communities achieving the potential that they are capable of.

Place: To provide care in the most appropriate place for the individual and their family, not only offering treatment and support but self-management, prevention and promotion of health and wellbeing.

Partnership: To create a sustainable care system in the city by organisations across all sectors, and the community, working together to use its combined resources appropriately and effectively.

From the endorsement of the blueprint it was agreed the next steps should be:

- Further analysis to gain as full as possible about the different at risk groups in order to understand what the co-ordinated care offer needs to be
- Assessment of our current service models(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 co-ordinated care in the community to live longer and live better.

This chapter addresses the above and highlights that our aim is to co-ordinate care around individuals and families in the community, so that individuals and families are empowered, communities are resilient and the systems are sustainable.

A3.2.2 New commissioned care model(s)

We are proposing that organisations that commission services for the people of the city will need to come together, in a partnership, to agree care models based on the population groups we are serving. A list of commissioners involved in integrated care in Manchester is given at A3.3.10 below.

This will mean that wherever you live in the city, based on your needs, you will receive a consistent offer of care, and we will measure consistent patient-centred, as well as disease and process, outcomes to see whether we are achieving what is needed and expected. Therefore, our agreed care models will be able to give all people in Manchester a consistent offer and an agreed outcome.

Our care model(s) will be based upon the principles that we are commissioning a model for people with lives, not patients with conditions. We will use a model that crosses the life course and understands the communities and cultures people live in.

We shall not restrict provision of care to the traditional service models or historic service providers or venues. Instead, the people of Manchester shall be empowered by being able to access the care that shall most benefit their wellbeing, at the right time, in the most appropriate place, from the provider of care that is best placed to meet their personal needs.

We will define our population based on the characteristics of who people are and where they live, and the goals and concerns they have.

Our commissioning care model(s) will be for a 100% of our population and within that approach we will segment and prioritise the population into groups and communities. This will mean we can focus care models on outcomes for individuals and their families. We will aim to have a universal as well as a targeted approach to treatment, prevention and promotion in the city. By effectively prioritising our resources together on those most in need we will aim to get the best value for money for the services we deliver.

By segmenting the population into three risk bands as described in the people domain chapter, we have been able to further define the population into specific groups of people. This seems the most appropriate way to define our care models. Once this is established there is then a need to define new delivery models that cross partner organisations and can deliver care to the agreed care models with shared success measures.

The table on the following page shows the population segmented in particular sub-groups of people, who they are, their risk band, characteristics, concerns, outcomes, proposed offer and components of a model.

In the table, note that primary care is a function not a profession, primary care is all the practitioners that might deliver care through a core contract i.e., GPs,

Table 3, sub-groups of Manchester's population

Population Group	Concern – Outcome Examples	Commissioned Care Model Offer - Examples	New Delivery Model Components - Examples
•Adults and Children who are carers •Older People over the age of 75 who are unwell •Children in their early years 0-4 •School and college children who need promotion to prevent accident and illness •Adults in work within our organisations who need to change the way they are	**Staying Healthy to live longer and better** Increased quality of life Fewer accidents Fewer illness Reduced time off school Reduced time off work Reduced time away from family	Education and information Self management Support Appropriate response Call, triage, respond Self management Co ordinate tailored, short term package	Community Based Model School health Occupational health Public health Primary care (all) Business Sector Third sector Hospital Based for short term care Primary care (all) Urgent Secondary care for accident and trauma Ambulance Services
•Children and Adults with long term conditions, illness or significant disabilities but who are generally functioning well	**Living with illness longer and better** Longevity, limiting disease progression, accommodating environment	Appropriate response Call Triage and Respond Self management Co ordinated health and social care as needed	Community and Home Based Primary Care Mental health Services Community services, Social Services Planned Secondary Care, Intermediate Care Third sector
•Adults and children at the end of their lives	**Living better and dying well** Comfort , dignity, life closure, care giver support, planning ahead	Appropriate response, call triage and respond Self management Co coordinated health and social care, home and intermediate care	Home Based Primary Care, Mental health Community Services, Social Services Intermediate Care Third sector Planned secondary care
•Adults and children living with long term conditions, illness, disease or disability and are unwell	**Living Better and Dying well** Avoiding exacerbation, maintain function and specific advance planning	Appropriate response Call Triage Respond Co ordinate health and social care Home based care	Home Based Primary Care, Mental health Community Services, Social Services Intermediate Care Third sector Planned Secondary Care
•Older People with dementia and/or frail elderly	**Living Better and Dying well** **Support, maintain function, advance planning**	Appropriate response Call Triage Respond Co coordinated health and social care Home based care	Home Based Primary Care Mental health Community Services Social Services, Intermediate Care Third sector Planned Secondary Care
•Adults with chaotic lifestyles such as the homeless, people with serious mental health problems, people with addictions or those in troubled families	**Living with illness longer and better** Autonomy, rehabilitation, limiting progression, accommodating environment care giver support	Appropriate response Call Triage and Respond Self management Co orientated health and social care as needed rehabilitation and Intermediate care	Community and Home, Based Primary Care Services Mental health Services Community Services Social Services Planned Secondary Care Intermediate Care Third sector

pharmacists, dentists, optometrists as well as the wider primary and community team.

A.3.2.3 Priority sub-groups

As identified in the previous chapter there are 10 sub-groups of people crossing the low, medium and high risk bands that we feel are the people we need to focus on to achieve the most impact in the next 5 years. As previously stated the progression from low to moderate, high and very high risk of admission is not a smooth one and there is clear evidence for the existence of steps between each risk category.

The sub-groups that have been identified are:

Very high and high risk sub-groups

- Adults and children that are at the end of their lives
- Adults and children living with long-term conditions, illness, disease or disability and are unwell
- Older people living with dementia and/or are frail elderly
- Adults with chaotic lifestyles such as the homeless, people with long-term mental health problems, people with addictions or those in troubled families

Moderate risk sub-groups

- Children and adults with long-term chronic conditions, illness or significant disabilities but who are generally functioning well.

Low risk sub-groups

- Adults and children who are carers
- Older people over 75 who are well
- Children in their early years 0-4
- School and college children who need promotion, information and support to prevent accident and illness
- Adults in work within our organisations who need to change lifestyles, and our perception of how we care, in order to actively deliver and promote living longer living better

A3.2.4 New delivery models

By designing care models based on a population approach that focuses on the individual, family and community there is a need for new delivery models to be designed that are co-ordinated, performance managed programmes of care, not individual stand alone projects. We believe that there is strong evidence that this design of model best achieves the outcomes for the individual, family and community as it is based on organisations working together around identified needs.

We believe that the new delivery model(s) will need to be co-ordinated around the full range of a person's needs and therefore cannot be achieved by one organisation alone, making every contact count. We want to promote new delivery models which enable organisations in our city to come together to offer, co-ordinate and integrated care by working together across sectors, boundaries and interfaces. Therefore we are not stating what the new delivery model(s) should be for the population groups identified, what we are stating are the care components that should be offered and the outcomes that we should aim to achieve. It will be for each of the organisation, with partners, to draft up new delivery models which will offer these care components and best achieve these outcomes by November.

These new delivery model(s) will need to use the resources and expertise from a range of people and organisations. These may include primary care, mental health services, community services, social services, housing, planned secondary care, intermediate interface services, the third sector, business, education, sport and leisure, service users, carers, communities and faith groups. We need to aim for a shift of resources from services that do not offer the care model we are promoting to new delivery models to ensure that there is a sustainable system. Therefore, the new delivery models drafted for November need to build into their design how they will shift resources to where they are most needed. We would aim for a shift of resources from the current urgent care models into the new delivery models for the very high, high and moderate risk groups.

Across sectors partner organisations in the new delivery models will need to work to the same explicit shared goals and be measured against the same success criteria, goals and objectives. Depending on the population group we will need to have new delivery models that either deliver across the city, in our three localities, or in smaller defined communities to achieve the care model.

We want to see far less reliance on organisational location of services. By using technology we can start to have a far more responsive and mobile workforce with the main focus for delivery being where a person lives, their home and their community.

We want the new delivery models to be team based and not bound by organisations, institutions or locations. The teams may be long standing teams that will work together in defined team structures. Alternatively, they may be groups of practitioners who come together, possibly virtually for short episodes, form a team to address a particular need of an individual or community and then disband.

Our new delivery models will move towards a far more socialised model of medicine, with interface management of specialist and generalist functions being needed. This will need a change of culture to enable team working which is dependent on knowledge of role and issue.

We have carried out an initial assessment of the range of NHS and social care services that we would identify as being focused on integration at present. Whilst there are excellent examples of services and projects, the issue is that they are not focussed on a shared care model across commissioners and providers. Therefore they are not co-ordinated or working to consistent offers or outcomes for the population groups described above. They are also not seen as core business for the organisations. There are also large gaps, not only in our knowledge of how other sectors work and what we could do more effectively, but also in capacity if we are to provide more care closer to home.

We acknowledge that if we promote new delivery models it will mean that we will need to work differently across our organisations and this will impact on our traditional core business and how we work with partners. However, we believe that working together on focused programmes of delivery is the right and appropriate thing to do to deliver the best models of care for the people of Manchester. We will need to assess how the new delivery models may change what our core business is, in order to deliver care which is responsive to the goals and concerns of individuals and families and meet the agreed outcomes and measures for the service and system.

This cannot be left to good will and partnership working alone as we need to be assured that services will be delivered to the highest standards, outcomes will be measured and be monitored. Therefore, we will need to create a different environment by which organisations can deliver integrated services to the agreed care model(s). This needs to be an agreed contractual period of time that enables them to design, deliver, evaluate and shift resources in order to achieve sustainability. This will be detailed in the chapters on system and resources.

A2.3.5 Components of the care models

The next section outlines for each of the 10 groups the proposed care model components, success measures and new delivery model partners.

We recognise that everybody is individual with unique needs and therefore some people in each of the groups will not always fall into the following risk bands; indeed some may move in and out of them as their needs and their life changes. Our care model will ensure that whichever category they are in, their care offer will be consistent and wrapped around their needs.

Model for the three sub-groups in the very high and high risk bands

Most of the people in our high and very high risk band will be known to services across health and social care. However, currently, as a system, we do not co-ordinate care around individuals and families as effectively as possible, as when there is a crisis many of these people attend A&E or are admitted into hospital when this may have been avoidable. Whilst some people in this risk band may need a period of hospital care to enable them to

stabilise; there are some people who currently come to hospital because there is nowhere else for them to go.

The task is for the new delivery model to be designed and delivered at scale and pace. We believe that we have many of the services in place but they are not operating at the right scale, and are not co-ordinated or operating over a 24/7-time period. The sustainability of these new delivery models will depend on the models being able to shift care and resource from the acute sector into the new delivery model over time.

Who • Adults and children that are at the end of their lives • Adults and children with living withlong-term conditions, disease or disability • Older people living with dementia and/or are frail elderly • Adults with chaotic lifestyles such as the homeless, people with long-term mental health problems, people with addictions or those in troubled families.	**Why** • 1.5% of our population pyramid. • Average age 64-5 • 20% people are not on registers – of these the largest group was children who had been admitted to hospital with asthma/wheeze or other respiratory problem • £33,237k urgent care spend • Average emergency activity cost per person in the very high risk group is £7,260 and in the high £3,020 • Average length of stay for the very high group 23.2 days • Over 218,000 emergency bed days in 2012 • 32,621 A&E attendances • 353 permanent nursing home placements funded by MCC • 1,360 permanent residential home beds funded by MCC
Care model components • Home and community based with hospitals providing care only when a hospital is the most appropriate location • Proactive, planned, co-ordinated care from a range of health and social care providers (either statutory or voluntary) • A dedicated health and social care 24-hour, 7-day-a-week call, triage and urgent response service within 4	**Success** • Increased quality of life for the service user • Increased satisfaction with care and support • Increased number of people who die with dignity in their place of choice • Increased number of people living in comfort • Increased number of people in control of their care plan • Reduction in use of urgent care services resulting in a shift of

hours to the patients' home or community setting. • Known care plan and key worker • Self-management and the use of telemedicine • Shared risk registers • Co-ordinated services across sectors, step down and step up • A continued care model for periods when they may be hospital with a known community key worker.	resource to the new delivery model • Reduction in use of institutional bed days in hospitals, residential and nursing homes resulting in a shift of resource to the new delivery model. • Improved health literacy which leads to improved self-management and compliance (e.g. with medication) • Consideration of improved medicine management and compliance leading to reduced complications and admissions
New delivery model partnership examples NWAS, health providers in Manchester, social care providers in Manchester, technology sector, carers, community and faith groups	

Model for the two sub-groups in the medium risk band

Most of these people will again be known to our services; however we have not achieved a co-ordinated approach to their care particularly across the different health sectors when people are living with chronic conditions. We do have good examples of services that are delivering innovative and co-ordinated care for adults and children. However this needs to be done at scale and pace in the three localities to achieve the care model and start to make new delivery models sustainable. The sustainability of the new delivery models will be dependent on being able to deliver a new way of caring for these groups, that is far more focussed on self management and co ordination between the sectors, preventing duplication and emergency admissions through exacerbation.

Who	**Why**
• Children and adults with long-term chronic conditions, illness and long-term mental health problems or significant disabilities but who are generally functioning well.	• This equates to 4% of our population. • £25,656k urgent care spend • 31,546 A&E attendances • 46,683 emergency bed days • Average emergency activity cost per person is £1,200 and planned care cost £1,286 • Gap between modelled and actual prevalence of people on long-term conditions registers

Care model components	Success
• Home and community based with hospitals providing care only when a hospital is the most appropriate location • Proactive, planned, co-ordinated care from a range of health and social care providers (either statutory or voluntary) • Appropriate urgent or planned health and social response through call, triage and respond. • Shared risk registers • Integrated pathways for specific conditions • Shared care management plans • self-management • Peer and group support • Technology increases i.e., apps and tele-health/tele-care • Advanced self care planning to keep healthy and avoid crisis	• Improved quality of life • Improved home environment • Increase in those who manage their own conditions Increased satisfaction with care • Increased self-management • Reduction in days lost at work and school • Reduction in the use of urgent services resulting in a shift of resources to the new delivery model • Reduction in use of institutional beds resulting in a shift of resources to the new delivery model • Reduction in medication use resulting in a shift of resources to the new delivery model • Improved health literacy which leads to improved self-management and compliance (e.g. with medication) • Consideration of improved medicine management and compliance leading to reduced complications and admissions • Reduction in days lost at work
New delivery model partnership examples NWAS, health providers in Manchester, social care providers in Manchester, technology sector, carers, community and faith groups	

Model for five sub-groups in the low risk band

We feel strongly that we need to focus on these groups and deliver new delivery models. Some of these groups are vital to providing care for the very high and medium bands. All are the bed-rock of the population that we need to work with to change perception and behaviour, promoting a different way of viewing care, health and well being.

Carers are vital to how we will deliver services in the future and we need to care for them. Their health will have an immediate impact on what we are trying to achieve for the new delivery model for the groups of people who are most at risk.

We have already defined an Early Years model which is being piloted in the city in three communities. However, the model is dependent on a significant number of commissioners and providers. This group has not been seen as part of the wider health and social agenda for the majority of NHS health providers and commissioners in the city. Therefore, by highlighting the Early Years new delivery model as a crucial part of *Living longer, living better* we will start to co-ordinate the agendas across the city. We will be able to capitalise particularly around the work to be undertaken on partnerships of commissioners and providers to accelerate the scale and pace of this programme of work.

School and college age people are our city's future. We feel strongly that we need to focus on them if we are to achieve a city that has a changed perception of its health and well being, and a population that understands the role of the individual as well as the community in being able to live longer and live better. We also feel that we can learn from our young people about what they will want from services in the future and how they will want to use e.g. technology to manage their health and well being. Our services currently deliver promotion and care to this group, however it is not seen as core business for our systems. If we are to move to a city where citizens achieve their aspirations and goals, this group of people need to become central to our priority programmes of work.

We want older people in our city to be, and stay healthy. Therefore, we need to care for those that are now growing old well, so that we can maintain their health for as long as possible. We also need to learn how we can care for older people more appropriately and effectively as we start to change the health profile of the city.

Our employees should work in organisations that promote the goals of *Living longer, living better* and the new delivery models. We need to have work places that people can have easy access to health checks, screening, information and promotion. We need to promote healthy lifestyles and enable people to achieve it whilst working, with incentives for exercise and life style change. Ultimately we want every employee to be an ambassador and role model for what we are trying to achieve – to be part of a social movement to change culture and perceptions about health and well being.

Model for five sub-groups in the low risk band

Who	**Why**
• Adults and children who are carers • Older people over 75 who are well • Children in their early years 0-4 • School and college children who need promotion and prevention skills	• 506,566 people, 94.5% of our population. • 37,000 Early Years children • 115,910 school and college children • 40% of our children live in poverty • 17,965 people who are 75 (+) years old and at low risk

• Adults who work within our organisations who need to advocate and deliver the new models of care	• 42,640 people in Manchester identified that they were providing unpaid care. There is still an issue of people not recognising themselves as carers and therefore the figure of actual carers is likely to be nearer to 60,000 (2011 census). The only figures we have relating to Young Carers is from the report 'Young Carers in Manchester, – Exploring their lives and experiences) commissioned by Manchester City Council, Morris Hargreaves McIntyre The number of young carers in Manchester in 2009 was 12,000 (16% of the population). This is based on research conducted by (Morris Hargreaves McIntyre 2009, together with figures drawn from a range of national studies) • 24,466 people work within our 7 of our 8 organisations • £42,090k urgent care spend • 298,165 A&E attendances
Care Model Components • Information and health promotion • Education • Screening and treatment closer to home • Peer and community support • Self management • Technology • Building a social movement for change[5]	**Success** • Increase in satisfaction with health and well being • Increase in people self managing • Increase use of technology • Increased health screening • Increased health checks • Increase in exercise • Increase in volunteering • Reduction in accidents • Reduction in the incidence of chronic disease • Reduction in the use of urgent care services • Reduction in days lost at work and school • Improved health literacy –

	better understanding on how to use support available for personal benefit and improved wellbeing
New delivery model partnership examples NWAS, health providers in Manchester, social care providers, schools, colleges, employers, media sector, technology sector, sports and leisure sector, community and faith groups	

A2.3.6 Timeline for implementation and shifting resources

In focussing on the 100% of our population it is apparent that we are delivering and implementing some of these services already. We have carried out an initial exercise which has shown that the services we deliver are at times fragmented, focused on individual organisations or pathways rather than care models and projects rather than integrated sustainable programmes of services.

We will need to change to implement new delivery models and we will need to do so whilst maintaining some of the services in the short term, that eventually will be able to shift to the new delivery models. We believe this is at least a 5/7-year change programme which will move the city from its present position to one where the population is living longer and living better.

A3.2.7 Scale, pace, achievements/performance: next steps

We will need to work at scale and pace which means we will not get it all right at the beginning and will need to evaluate and change. Therefore it is vital that we are given the time to do this properly and that the new delivery models are given a 5/7-year programme to work to.

November 2013 – care and new delivery models drafted for each of the 10 groups

December 2013 - care model(s) agreed for the 10 groups by a partnership of commissioners

April 2014 – new delivery model(s) agreed by a partnership of providers for the 10 sub-groups, in each system and/or across the city, taking into account scale, pace and impact for implementation. It is envisaged that the delivery models for groups in the very high/high and medium risk will need to be implemented first to release resource to implement other changes.

April 2015 – measure, act on results, and change the models to improve

April 2015 – start to shift resources to be able to sustain the new delivery models

2015-20 - continuous cycle of measurement, improvement and shift to achieve goals and sustainability

A3 The key domains

A3.3 Our contracting and funding

***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."

A3.3.1 Introduction

Contracting and funding of health and social care services is a key enabler of effective care delivery. Without alignment of contracting and funding with the desired care model the resource and accountability for delivery will not be matched and therefore the care model and ultimately outcomes for the population are less likely to be achieved. The changes to contracting and funding outlined in this section can be described as 'game changing' in the way services are funded and held to account for outcomes.

The aims of the reform of contracting and funding models within the city's health and social care system are:

- To get best value from the public sector budget in terms of outcomes per pound spent.
- To ensure that the care model is delivered coherently and services are not fragmented by organisational, professional or specialty boundaries.
- To direct the right money to the right place in order to adequately and sustainably fund the right care as defined by the care model.
- To financially reward positive outcomes for the population's health and wellbeing
- To support the process of transition to the new care model from the existing one.

This section progresses the thinking from the *Living longer, living better* vision document to make proposals around the best contracting and funding models. It follows a literature review of contracting and pricing models and a workshop of a group of members of the citywide leadership team with finance and contracting professionals, together an expert external advisor, within the health and care system.

The Kings Fund recently produced a paper[6] which described key lessons learned elsewhere to make integrated care happen at scale and pace. All are relevant to contracting but some are very specifically. These are listed below.

Lesson 4 Establish shared leadership

Lesson 8 Pool resources to enable commissioners and integrated teams to use resources flexibly.

Lesson 9 Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector.

Lesson 15 Be realistic about the costs of integrated care.

Contracting

A3.3.2 Context

There are a number of contracting models which have been assessed as part of this exercise. In that assessment a basic set of principles was discussed in which a contract would operate, key success factors would be established and a shortlist of models developed. Ultimately the final choice of contracting method will be determined by the care model(s) when established. Different options may be used in different circumstances so this paper does not fix on one type of contract at this point.

A3.3.3 Principles

Agreed principles specifically underpin alliance contracting (described below). Although alliance contracting is not necessarily the option *Living longer, living better* will take forward it is felt that even outside of the contracting model a set of principles the system can work to can add real value. These principles transcend contracting and apply to how the system works as a whole. For this reason they should be adopted at a Chief Executive/Chair level, potentially as a list of principles the Health and Wellbeing Board sign up to. A list of principles has been explored which are listed below.

We will:

- Achieve clear and tangible improvement measures based on outcomes, resources and the care model.
- Work with the population we serve treating them as a key contributor to the care model.
- Support clinical leadership and clinically led service developments.
- Invest in evidence-based interventions, capturing the evidence where it doesn't currently exist, understanding the costs and benefits and using this as the basis for future commissioning/decommissioning decisions.
- Adopt a patient-centred, outcome-based approach and make decisions on a 'Best for System' basis.
- Strive to resolve disagreements cooperatively and, wherever possible, achieve consensus.
- Make best use of finite resources in planning and delivering health and care services to achieve improvements for our population.

- Adopt a transparent and open approach to sharing information.
- Be collectively responsible for all decisions.
- Be professional, supportive but challenging in working together.
- Be mindful of working with, and our impact upon, the system around us.
- Support each other in management of risks, 'your problem is my problem'.
- Be well governed and have strong levels of assurance.
- Learn from our successes and failures.
- Plan for the long term.

A3.3.4 Options considered

Informal network

Providers and commissioners meet to develop the system on an informal basis. They set joint aims and objectives but there is no contractual arrangement. They also work together operationally to manage overall service delivery.

Accountable care organisation (ACO)

This is in effect a network or consortium of provider organisations who agree with the commissioner service delivery or outcomes. The ACO is not a legal entity but has an identity/brand. They share with the commissioner and their partner providers any financial gains or losses in the arrangement. The commissioner still holds contracts with providers individually.

Integrating pathway hub (IPH)

A single entity/provider takes on responsibility for the management of providers along a care pathway. The commissioner contracts with the IPH and providers separately. Clinical and financial accountability is with the IPH provider.

Prime contractor

The commissioner(s) hold one contract with one provider which has full accountability for the care model. The prime contractor subcontracts some provision to other provider organisations and will determine any risk and benefit sharing arrangements with them.

Integrated care organisation (ICO)

A new provider organisation is established to manage delivery of the care model.

Alliance contract

The commissioner(s) have one contract with a formal alliance of providers who work to one performance framework. They work to a set of principles, agreed decision-making process and accountability including sharing risk and rewards relating to the contract. At a strategic level the commissioner will form part of the governance but not at a tactical or operational level.

Do nothing

For Manchester in contracting terms there are a number of fora which could constitute some progress towards an informal network. The current system has established networks which are evolving and developing but not yet operating to their full potential.

A3.3.5 Key success criteria

In discussion of various contracting options a number of key criteria emerged by which any contracting options might be measured. The success criteria reflect the learning from the community budget work in 2012 and in particular the 'proof of concept' work to develop a model for integrated care for the 'high' and 'very high' risk people in Manchester.

These are:

- The ability to contract for an outcome for a population group.
- Focus upon a population, rather than a condition, provider or disease area.
- Practicality of phasing to a new model from the existing one.
- Feeling of partnership and equality of relationship.
- Decisiveness of decision-making.
- Complexity of relationships (number of commissioners and number of providers).
- Ability to shift money.
- Flexibility to work with a segment of the population e.g. patient cohort, geography etc.
- Commissioner assurance regarding quality and safety.
- Contingent upon a long-term contract (5-7 years) to succeed.
- Provider regulations e.g. Monitor licence.
- Recognition of provider roles within other contracts and systems.

A3.3.6 Shortlisting

The following table shows the options for contracting assessed against these criteria.

	Contracting for an outcome	**Focus upon population**	Practicality of implementation	Partnership & Equity	Decisiveness of decision making	Complexity of relationships	**Ability to shift money`**	Flexibility to cohort of population	**Commissioner assurance regarding quality and safety**	Contingent on long term contract to succeed	Provider regulations e.g. monitor licence	Recognition of provider roles within other contacts/systems	Overall view
Informal network													
Accountable Care Organisation													
Integrating pathway hub													
Prime contractor													
Integrated Care Organisation													
Alliance Contract													
Do nothing													

Table 3, shortlisting of contracting options

Key

Green	Fit for purpose with some dependencies
Amber	Fit for purpose but with moderate to significant dependencies
Red	Not fit for purpose

Those headings in bold are considered to be fundamentally important so if any are rated red the model has been excluded.

A3.3.7 Shortlist

The shortlist of contracting models to be further reviewed and potentially drawn upon are as follows.

- Informal network
- Accountable care organisation
- Prime contractor
- Alliance contract

It is likely that different contracting models will suit different situations and there will be different models used to achieve different outcomes for different population sub-groups. It is also likely that the care models will be prioritised in terms of implementation and the contracting arrangements would follow that. The existing contracting arrangements are likely to stay in place as the default mechanism.

A3.3.8 Contract scope

The contract model chosen would be determined by the care model and the specific objectives it seeks to achieve and the dynamics of organisations involved in the population group. It is likely that there will be a number of contract arrangements each focussed upon population/care sub-groups as determined by the care model.

A3.3.9 Contract term

The system needs to consider longer-term contracts. The changes described in the vision document and the care model will take years to achieve and will require investment and shift in workforce. Therefore provider organisations, individually and/or in alliances, will need to have the confidence to commit their resource over the medium to long term and potentially make financial losses is some parts of their business in the early years. Commissioners can agree trajectories over the period of the contract in both outcomes for people and cost of service. This would allow both a shift in investment between parts of the pathway within contracts and also shift resource over time between contracts. Extended contract terms and multi-year allocations for commissioners would be one of the key flexibilities the system might seek from being one of the 'Pioneer' sites announced by Government. Five to seven years is considered to be the minimum to allow providers/alliances to make meaningful investment of time and resource into delivering the change required, particularly where a capital investment is required.

A3.3.10 Implications for commissioning

In terms of contracting such models commissioners will need to adapt how they work. There are currently six commissioners of health and social care for the population of Manchester. Manchester City Council commissions social care and public health services. The three Clinical Commissioning Groups commission the majority of health services for their respective areas of North, Central and South Manchester. NHS England commissions primary care services for Greater Manchester via its Greater Manchester Area Team and specialist services are commissioned for the North West of England by the Cheshire and Mersey Area Team.

Commissioners will need to coordinate their activities to ensure that provider(s) have either one contract or a common thread across contracts to ensure a coherent delivery by providers and a coherent offer to the public.

Commissioners will also need to consider how Manchester focussed work fits with wider system reform programmes such as *Healthier Together* and the need to make the work across our boundaries taking account of resident and registered populations.

A3.3.11 Provider regulation

Provider organisations in Manchester work within very different arrangements depending upon the type of organisation they are. There are NHS organisations, council run services, private sector and voluntary sector amongst others. Each will have different strategic and operational considerations to make and potential regulatory barriers to bridge before entering into new contracting arrangements. For instance foundation trusts need to have certain assurances relating to their license. These assurances relating to risk management, clinical standards, income projection. The impact of new contracting arrangements would, as a minimum, need to be assessed against these areas of assurance. Regulation arrangements may well present a barrier to an organisation entering into such an arrangement if it were of a material size.

Funding models

A3.3.12 Context

The role of funding, and in particular, determining ways of moving money around the system, has been a central part of the community budget and public service reform work in Manchester. Money and resources have been invested at a small scale in new service models in North, Central and South Manchester. However, the challenge is to identify models which can be practically used at the scale required by the care model described in this document.

Before discussing funding methods it is useful to set out some thinking about considerations when appraising options. The Nuffield Trust reviewed pricing/funding models and how they have been deployed in a recent publication. It drew out some key lessons which can be used in Manchester's assessment of options.

Nuffield Trust – six lessons[7]

- Policy makers overestimate the power of payment systems to fundamentally reshape the healthcare system
- Policy makers have loaded a larger number of objectives onto the payment system – some contradictory
- Each type of payment system has its own set of unintended undesirable consequences
- Payment systems are different in different sectors bringing no mutual incentives for professionals to work together, sometimes the reverse
- There is much to do to improve the quality of costing and pricing especially how to fund capital (specifically replacement of estate).
- Introducing new payment models into areas where it is harder to categorise patients e.g. year of care or within population groups is more difficult and takes longer than expected.

A3.3.13 Options

In the Nuffield Trust paper it also identifies three dimensions by which payments are made. Each option discussed in this section has one or more of these aspects within them.

- Degree of bundling (grouping activities and services together in one payment)
- Whether payment is set prospectively or reimbursed retrospectively
- How best to reflect the performance of the provider

Activity-based payments

These are typically in two forms. Firstly, payment for a completed episode of care for example the outpatient, inpatient and rehabilitation for a hip replacement bundled into one payment. Alternatively payment by results, the means by which hospitals are funded, would pay for each of those components separately e.g. three outpatient tariffs, an inpatient elective procedure tariff followed by further outpatient tariffs. The key advantage of activity-based payments is that it reflects volume of work and, therefore, cost which means providers can be adequately funded. It also supports competition between providers as the flow of money will shift based upon where the referral is made. Tariffs have also significantly driven productivity improvements and reduced waiting times. However, they have had some negative consequences. They cause uncertainty regarding commissioner cost and provider income as demand and throughput will determine cost and income. They incentivise quantity but not quality and can cause providers to scale down unprofitable services.

Block contract payments

Block contract payments are a fixed fee to provide a range of services. This does not take into account demand levels. This method brings financial certainty to both provider and commissioner but has been criticised for not generating either quantity or quality of service from a commissioner perspective or bringing demand risk from a provider perspective. Community services and mental health services have historically been paid for on this basis.

Cap and collar

A cap and collar arrangement is where there is an activity based contract but with upper and lower limits to the total contract value. This helps manage the financial volatility of an activity-based contract whilst not encouraging over production as the activity-based element is often at a marginal (no gain no loss) rate. Urgent care secondary care contracts have been established on this basis over the last few years. This has given a mutual incentive for commissioners and providers to reduce overall activity in this sector.

Capitation

Capitation budgets are fixed fees for management of care of a population group. For example primary medical care services are partly funded on a fee per registered person. This can bring a population and prevention orientated focus but would not necessarily promote improved productivity or quality of service, with the exception of where capitation funding has been within a competitive market.

Outcome-based risk reward mechanism

This method funds providers based upon the outcomes they achieve based upon objectives set through the contract. It is referred to as Pay for Performance (P4P). This is typically used as relatively small part of contracts typically 5-10% e.g., CQUINs via the NHS contract and to a greater extent through QOF in the GP contract. They are useful forms of incentivising quality but they are often difficult to agree, define and measure objectives. However, it is recognised that this has often resulted in process/output measures rather than outcome measures.

A3.3.14 Appraising options

The choice of funding mechanism is more reliant upon the detail of the care model and each funding mechanism will suit different models and contracting types better. There may need to be a variety of different methods used within the system. However, a series of measures by which options would be appraised is listed below.

- Stability i.e. level of fluctuation in demand.
- Financial risk of commissioner/provider.
- Future direction of care model/service e.g. growth/reduction over time.
- Ability to define and measure outcomes or link process/output measures to outcomes via evidence.
- Ability to align incentives across sectors.
- Flexibility against national frameworks.
- Fixed cost investments required over time.

A3.3.15 Conclusion

- The best choice of funding mechanism will be determined by the care model i.e., the care model needs to determine the objective that the payment will be designed to meet.

- Whatever mechanisms are put in place there should be a clear and common set of performance measures linked effectively to part of provider income. They should build reliance between all providers responsible for delivering upon outcomes to achieve these incentives or suffer the risk of not doing so. In effect this could mean aligning CQUINs across hospital, community and mental health with QOF in primary care to be related to system level outcomes.

- The use of combinations should be assumed as the system will need stability of a fee for service provided but needs more effective pay for performance methods.

- Bundling payments across sectors to support closer integration of care and flexibility to shift money between sectors based upon best value. This coupled with pay for performance is a growing trend across Europe, specifically relating to chronic disease management.

- The system should not expect the outcome to be achieved by financial measures alone.

- Transitional financing should be considered to account for capital investment and double running costs.

- The new financing arrangements should avoid creating an industry of granular transactional level costing and analysis which will consume resource and draw attention away from the goal.

A3.3.16 Competition and choice

Further work will be required to assess the considerations which need to be made in taking forward new funding and contracting models. In April 2013 the Health and Social Care Act 2012 changed both the approach to competition and choice and the basis by which commissioners and providers are regulated in relation to this by Monitor. The guidance relating to this is still emerging. This change is more focussed upon how competition and choice take place in the NHS but doesn't change broader legal requirements regarding procurement.

There are two key questions to consider in relation to taking forward this work.

What obligations, legal or otherwise, the system has in relating to competition and choice?

What considerations should be taken into account when assessing the potential benefits or disadvantages competition might bring.

Specific considerations could be:

- Implications of entering into longer-term contracts in terms of procurement requirements and on-going assurance regarding performance and quality.
- Implications of holding prime contractor or alliance contracts. Would this support quality improvement through closer working and aligned incentives or reduce the levels of competition between providers and therefore the need to improve quality.

- Would unreasonable competitive advantage be gained by providers within an alliance contract and this increase barrier to market entry?
- What are the implications of providers working within an alliance whilst they still are competing with each other within the wider market place?

Commissioners may seek to look at competition differently. Historically competition has been between providers at a particular part of the pathway e.g. Independent Sector Treatment Centres competed with acute trust to provide joint replacements or nursing homes competing to provide care placements. This competition certainly created capacity and made a positive impact upon waiting times but due to the lack of finite demand has been argued not to have driven up quality. Porter[8] has argued, however, that competition works better on pathways e.g. a provider will bid to provide an end to end diabetes pathway so competition would work vertically rather than horizontally and accountability for outcomes for that pathway is held within one entity. Whilst Porter argued this for pathways the logic equally applies to population sub-groups. Currently this type of competition is limited due to the sectorisation of the health system. Emerging contracting models could create a more positive form of competition.

A3.3.17 Risks and issues

There are numerous risks associated with moving towards these new models. The materiality should not be underestimated nor should the difficulty of resolving them. Assurances should be reached regarding resolution or mitigation of these risks before any significant changes are made.

- The issue of the full level of trust between partner organisations has been raised as a risk to closer contractual working.
- General Practice is a strong partner in a commissioning role but does not have a strong presence as a provider in terms of having a means of working with the whole of that sector. This is the same for other primary care contractor groups i.e. community pharmacy, dentistry & optometry. Primary care services are commissioned at a Greater Manchester level using nationally determined contract mechanisms.
- CCGs currently have one year allocations which are in a period of instability following recent organisational changes. City Councils have longer settlements but have increasingly challenging financial circumstances. There are also restrictions against longer-term contracts. Some contractual forms would require 5-7 year contract periods to allow provider to invest time and resources into making meaningful change.
- The potential partners within any alliance will have different organisational size, levels of resilience and roles within the system. They will have different externally determined funding sources based upon either place of registration or place of residence. They will have different forms of regulation e.g. Monitor, Care Quality Commission etc. Organisations will also have partnership arrangements with organisations outside of Manchester. This will mean decisions or

issues will have different impacts upon organisations within the partnership which will complicate and potentially impact upon progress.
- Organisations, within the partnership will have different business models and organisational objectives. There will inevitably be a tension between the partnership aims and direction and those of the organisations within it. This is the strength of having effective collective leadership, principles to work to and development of mechanisms to manage risk where these tensions emerge.
- Competition and choice requirements will need to be built into any plans and whether a competitive process is or isn't incorporated into any proposals will need a robust assessment.
- The process of managing the shift of substantial amounts of money is not covered in detail within this paper nor is the requirement to establish investment in infrastructure out of hospital.

A3.3.18 Recommended next steps

The recommended next steps for contracting and funding are:

Health and Wellbeing Board

- For the system, under the leadership of the Health and Wellbeing Board, to agree some high level principles by which organisations work. These will then be built into contracting models and consideration should be made to using them more widely.
- To support the shortlist of contracting options and assessment of these against the care model alongside sources of funding
- To support the conclusions relating to funding options as the basis for further work.
- To support the establishment of new contracting model(s) at least in shadow form by 2014/15.
- To note the risks highlighted within the report, the level of materiality of these and the requirement to resolve or mitigate these
- To acknowledge the requirement for investment and transitional funding to develop the new system.

Citywide leadership

- To build into the Greater Manchester Pioneer site application a requirement to gain the flexibilities required to enter into these models, particularly around longevity of contracting/financial cycles.
- To assess contracting and funding models against the care models with the support of the reference group.
- To make recommendations to the Executive Health and Wellbeing Group regarding eliminating or mitigating risks.
- To establish and brief a sub-group to develop and implement a plan for establishment of new contracting models and financing arrangements.

A4 Recommendations

It is recommended that the Health and Well-being Board

- **Approve the contents of this document**
- **Approve the next steps and timetables set out at A3.1.11, A3.2.7, and A3.3.18**

Appendix 1 – The evidence base for integrated care

It is to be expected that a highly complex system such as integrated care is unlikely to have a single, simple, evidence base. It is not a technical solution to a 'tame' problem; it is a complex set of responses to a 'wicked problem[9]'. This is not the same as saying, whoever, that there is 'no evidence for integrated care.' On the contrary, evidence exists of varying kinds in most of the key components of integrated are, including:

- Population risk prediction
- Clinical effectiveness
- Organisational change
- Patient and carer perspectives
- Financial impact

No single publication has yet brought all of the evidence in all of these areas together, and given the importance of integrated care nationally and internationally, it is unlikely that any single publication ever could. The table below gives some pointers towards sources of evidence published in Great Britain in all of these areas.

	Integrated care area	Example of evidence, or source of evidence
1	Population risk prediction	The effectiveness of risk prediction tools (particularly the one used to underpin the *Blueprint* in Manchester) has been positively evaluated by the Nuffield Trust's *Choosing a predictive risk model: a guide for commissioners in England* (November 2011)
2	Clinical effectiveness	A search (2 May 2013) of the Cochrane Library (which collects systematic reviews of evidence for decision-making in healthcare) under the term 'integrated care' generated 577 results
3	Organisational change	There is a substantial history of publication in this field. Amongst the most recent important documents are RAND Europe and Ernst and Young LLP's study for the Department of Health, *National Evaluation of the*

		Department of Health's Integrated Care Pilots (March 2012) and Chris Ham and Nicola Walsh's paper for the Kings Fund, *Lessons from experience: making integrated care happen at scale and pace* (March 2013).
4	Patient and carer perspectives	There is an increasing history of publication in this field, also. Amongst the most important recent publications are Frontier Economics' report for Monitor, *Enablers and barriers to integrated care and implications for Monitor* (May 2012) and the report cited in the main text of the strategic outline case from National Voices, *A narrative for person-centred co-ordinated care* (November 2012)
5	Financial impact	A bibliography of the evidence of financial impacts in integrated care has been published by the Scottish Government at http://www.scotland.gov.uk/Publications/2010/02/19133206/8

Internationally, there is an equally diverse range of evidence applied to different healthcare systems including privately-funded systems. For example, the Kaiser Permanente model of personalised and co-ordinated care which operates in nine of the United States of America, has had a powerful effect on the thinking of the NHS and on social care services in England. The Kaiser Permanent approaches and the various organisational structures which deliver them have been evaluated in many ways, e.g., in July 2011 by SPEC Associates for the National Quality Forum: *National Priorities Partnership Evaluation Case Study Report: Kaiser Permanente Care Management Institute*. More recently, examples of effective integration have been identified in Europe, a particularly strong example being the Alzira model in Valencia, Spain. This model, which commenced in 1999, has been the subject of a number of papers in English, including the NHS Confederation's 2011 paper: *The search for low-cost integrated healthcare: the Alzira model – from the region of Valencia.*

Many publications offer learning from experience to guide work on integrated care elsewhere. The tables below summarises the key messages from two such publications, the Kings Fund paper of March 2013 by Chris Ham and Nicola Walsh referred to in the table above, and an earlier paper by Angus Ramsay and Naomi Fulop, *Integrated Care Pilot Programme: The Evidence Base for Integrated Care* (August 2008). In both cases, a summary is given of the application of each key message in Manchester.

Angus Ramsay and Naomi Fulop, 2008	**Application in Manchester**
Lesson 1. Integrate for the right reasons	Wide range of drivers for integration recognised, and patient benefit regarded as key
Lesson 2. Don't necessarily start by integrating organisations	No current proposals to reconfigure local organisations, e.g., into an integrated care organisation
Lesson 3. Ensure local contexts are supportive of integration	Extensive partnership work over several years as well as planning and service

	design fully takes into account local contexts
Lesson 4. Be aware of local cultural differences	Local cultural differences explicitly recognised, e.g., amongst the localities in North, Central and South Manchester
Lesson 5. Ensure that community services don't miss out	Community services are critical to the success of integrated care
Lesson 6. Give the right incentives	Financial incentives are explored in chapter A3.3; the community and engagement domain will explore opportunities for patient and resident incentivisation/behavioural change
Lesson 7. Don't assume economies of scope and scale	Chapter A3.1 of this strategic outline case explores in outline the economic case for significant increase in the scale of integrated care arrangements
Lesson 8. Be patient	Local planning and deliver of integrated care accepts that there is a demand to move at pace whilst at the same time working carefully and in a sophisticated manner.

Chris Ham and Nicola Walsh, 2013	**Application in Manchester**
1. Find common cause with partners and be prepared to share sovereignty	Excellent history of partnership working, and shared decision-making
2. Develop a shared narrative to explain why integrated care matters	Strong shared narrative, most recently in the *Blueprint*
3. Develop a persuasive vision to describe what integrated care will achieve	Benefits of integrated care set out in health and social care study (McKinsey and Co) and *Blueprint*
4. Establish shared leadership	Shared leadership demonstrated throughout governance structure for *Living longer, living better*
5. Create time and space to develop understanding and new ways of working	Significant commitments of time on a regular basis from senior leaders, managers and clinicians to programme
6. Identify services and user groups where the potential benefits from integrated care are greatest	Understanding the target population a priority for the McKinsey and Co health and social care study and the *Blueprint*, and a key priority for this strategic outline case
7. Build integrated care from the bottom up as well as the top down	Multiple examples of 'bottom up' integrated care services (summarised in chapter A3.1)

8. Pool resources to enable commissioners and integrated teams to use resources flexibly	Consideration of resource issues to follow from agreement on contracting principles set out in chapter A3.3
9. Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector	Proposals to implement optimising contracting and financing arrangements set out in chapter A3.3
10. Recognise that there is no 'best way' of integrating care	Pragmatic approaches taken to *Living longer, living better* programme throughout

Living longer, living better will continue to review the emerging evidence for integrated care, and, through its own evaluation (see B3.7) contribute to that evidence base itself.

Appendix 2 – Abbreviations

Abbreviation	Explanation
A&E	Accident and Emergency Department
ACO	Accountable care organisation
AQuA	Advancing Quality Alliance
BHPS	British Household Panel Survey
CKD	Chronic kidney disease
CMFT	Central Manchester University Hospitals NHS Foundation Trust
COPD	Chronic obstructive pulmonary disease
CPM	Combined predictive model
CVD	Cardiovascular disease
CQUIN	Commissioning for Quality and Innovation
GP	General practitioner
HES	Hospital Episode Statistics
HSE	Health Survey for England
ICO	Integrated care organisation
IPH	Integrating pathway hub
k	£1,000
LSOA	Lower layer super output area
MCC	Manchester City Council
MMHSCT	Manchester Mental Health and Social Care Trust
NHS	National Health Service
NMGH	North Manchester General Hospital
NWAS	North West Ambulance Service NHS Trust
ONS	Office of National Statistics
P4P	Pay for Performance
PAHT	Pennine Acute Hospitals NHS Trust
UHSM	University Hospitals of South Manchester NHS Foundation Trust

Appendix 3 - References

[1] Further information about the spend primarily on the very high and high risk groups by adult social care services, continuing healthcare and funded nursing care in 2012/13 is set out in the below:

Homecare: adults £10,320,000; learning disabilities £1,059,000; mental health £842,000.

Residential care: adults £24,791,000; learning disabilities £4,621,000; mental health £3,619,000

Re-ablement: £4,696,000

Equipment: £3,128,000

Continuing healthcare: fast track £699,000; learning disabilities <65 £2,195,902; learning disabilities >65 £208,100; mental health <65 £905,440; mental health >65 £3,521,720; physical disabilities <65 £5,914,382; physical disabilities >65 £9,038,745; other £2,852,707

Funded nursing care: £4,089,015

[2] Jordan, R.E., *et al*., 'Effect of social factors on winter hospital admissions for respiratory disease: a case control study of older people in the UK', *British Journal of General Practice*, 58 (551), 2008, pp. 400-2

[3] Bardsley, M., *et al*., *Predicting social care costs: a feasibility study* (London: Nuffield Trust, 2011)

[4] See Lynn, J., *et al*., 'Using population segmentation to provide better health care for all: the "Bridges to health" model', *The Milbank Quarterly, Vol. 85, No. 2,* 2007, pp. 185–208. Our thanks to Dr John Dean of AQuA for drawing this article to our attention.

[5] See 2012/13 annual public health report of Manchester Public Health at http://www.manchester.gov.uk/download/meetings/id/15051/6_public_health_annual_report_2012_13 discussion on a future national carers' support bill, e.g., http://www.carersuk.org/professionals/resources/briefings/item/2648-draft-care-and-support-bill-briefing

[6] Ham, C., and Walsh, N., *Lessons from experience: Making integrated care happen at scale and pace*, (London: Kings Fund, March 2013)

[7] Nuffield Trust, *Payment system reform: six lessons for the NHS from Europe* (London: Nuffield Trust, August 2012)

[8] Porter, M.E., and Teisberg, E.O., *Redefining healthcare – creating positive-sum competition to deliver value*, (Harvard: Business School Press, 2006)

[9] "Tame problems are akin to puzzles – for which there is always an answer….A wicked problem is complex rather than just complicated. That is, it cannot be removed from its environment, solved and returned, without affecting the environment. Moreover, there is no clear relationship between cause and effect. Such problems are often intractable." Grint, K., *Leadership: a very short introduction* (Oxford: University Press, 2010)

LIVING LONGER, LIVING BETTER

STRATEGIC OUTLINE CASE

PART B

June 2013

Contents

Living longer, living better strategic outline case

Executive summary

Introduction

NHS organisations in Manchester together with the City Council were asked by the Health and Wellbeing Board in March 2013 to prepare a 'strategic outline case' to increase the coverage of the city's 'integrated care' arrangements from about 2% of the population to 20%. This request was made following approval of a '*Blueprint*' for integrated care in the city.

'Integrated care' refers to advanced arrangements for organisations, teams and professionals working together to provide high quality co-ordinated to individuals and families usually in their own homes or in the community. Integrated care arrangements are intended to put service users or patients in control of their own care, and to reduce avoidable use of hospital and other services, especially emergency services. Manchester's plans for integrated care are known as the '*Living longer, living better*' programme.

A 'strategic outline case' is a document which sets out the detail of key parts of a future plan, and tests the underlying assumptions behind a planned change; in this case in health and social care services.

Our three priority areas

The leaders of Manchester NHS organisations and the City Council agreed to use the strategic outline case to describe in more detail three main areas or 'domains' of the city's plans for integrated care. These three domains are: our people (the city's population), our care model (the characteristics of integrated care services) and our contracting and funding arrangements. These three domains are described in part A.

Our work in other domains

This document, which is part B of the strategic outline case, contains information about the work we have been doing in other important domains, all of which rely on progress being made in understanding and planning developments in the three priority domains. These other domains are summarised below.

How our workforce will need to change

Many people are employed in the health and social care sectors in Manchester, with a wide range of different backgrounds, skills, qualifications and responsibilities. The wide-scale introduction of integrated care will have implications for many of our workforce, and some of these implications are described.

How our buildings and property can best be used in the future

Health and social care services use many buildings across Manchester, not always to best effect. Providing integrated care, and making best use of how we commission and use our buildings, are vitally important areas. This chapter includes a detailed summary of our existing buildings for health and social care use.

What information technology requirements there will be to support integrated care services

Good information is essential to integrated care, and so to enabling people to live longer and live better. We have many different systems to information technology in Manchester many of which may need further change and development. This chapter summarises our current arrangements.

Our health and social care system

Not only will integrated care require our organisations to work differently in the future, the whole system of health and social care will need to work and behave differently. This chapter sets out some of the ways in which the current system will need to develop further.

Public engagement for better health and wellbeing

Integrated care and *Living longer, living better* is not just for a small proportion of the population. As part A of the strategic outline case made clear, it is for everyone, and everyone has a part to play. Communicating this message, and engaging the whole of Manchester's population in the changes that *Living longer, living better* needs, is a major area of work. This chapter describes some of the initial steps that need to be taken in this field.

Our leadership

Change at the scale indicated in this strategic outline case will not happen without strong and effective leadership at every level, not just at the top of the organisations involved. Some of the qualities, styles and characteristics of leadership for integrated care are described in detail in this chapter.

Evaluating our progress

This chapter outlines our commitment to test and evaluate the impact of the changes we are planning to health and social care services, to make sure they achieve the goals we are setting out for them.

Conclusion

Taken together, we believe that the strategic outline case represents excellent progress in preparing our plans to help Manchester people live longer and live better. We hope you enjoy reading it!

Living longer, living better strategic outline case

Part B

B2. Introduction and background

Introduction

A detailed introduction to the strategic outline case for integrated care in Manchester – branded *Living longer, living better* – is provided in part A of this document. Part A also contains the details of three prioritised areas ('domains') namely: our people (the city's population), our care model (the characteristics of integrated care services) and our contracting and funding arrangements.

Part B contains details of the work that has been undertaken in the remaining domains as originally set out in the *Living longer, living better Blueprint*. For these domains, the primary goal has been to commence describing the implications for the contents of the domain arising from the more detailed work on our people, care model and on our contracting and funding arrangements.

The domains covered in part B are:

- How our workforce will need to change
- How our buildings and property can best be used in the future
- What information technology requirements there will be to support co-ordinated care services
- How our health and social care system needs to work together effectively, not only in contractual terms but also in terms of organisational and individual behaviour and the impacts of co-ordinated care on individual organisations and local systems
- How everyone affected by co-ordinated care arrangements and the system change that results from them can be engaged in helping make it work
- What our co-ordinated care leadership requirements are across the local system
- How the impact and effectiveness of co-ordinated care can be evaluated

B3.1 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."

B3.1.1 Introduction

We are aware that appropriate workforce redesign underpins safe and sustainable delivery of system transformation and the *Living longer, living better* programme. A key element of the programme of change is to understand what the future model(s) of care will look like and to put plans in place to ensure our workforce is developed and enabled to improve care outcomes within a sustainable care system.

This section describes some of what is already known about our workforce delivering elements of integrated care. It describes what we have that we can build on and what needs to be the focus of attention in the coming months. It will describe, based on what is currently known about the potential future care models/s, the likely areas for change and development. And finally it will set out the plans for more detailed assessment of the impacts of the changes to our future workforce requirements and the actions required in making progress towards the programmes aim.

B3.1.2 Our current workforce

Our carers in the city

Carers are defined in the national census as *'A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long term physical or mental health or disability, or problems related to old age'.*

Young carers *'are children and young people under 18 who provide care, to another family member who is disabled, or has some chronic illness, mental health problem or other condition connected with a need for care, support or supervision. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent but can be a sibling, grandparent or other relative'.*

Carer Group	Headcount
Carers[1]	42,640
Young Carers[2]	12,000

Table 1, carers in Manchester

In the 2011 census 42,640 people in Manchester identified that they were providing unpaid care, this is an increase of 24% from the 2001 census. The average increase in the same period across the North West is 8% and across England and Wales is 11%. There is still an issue of people not recognising themselves as carers and therefore the figure of actual carers in the city is likely to be nearer to 60,000.

The only figures we have relating to young carers are from the report on research conducted in 2009[2]. Whilst for some of our young carers a caring role can have positive aspects, for some we know the impact of caring will be having an adverse impact on their ability to enjoy a childhood and achieve the outcomes we want for the city's children and young people. The research highlighted the fact many young carers reported positive aspects to being a young carer. However, in the context of the programme of change that is *Living longer, living better* it is clear that we have a large and growing carer workforce in the city. We will ensure their needs and future requirements are considered as an equally highly valued part of our workforce.

B3.1.3 Our employed care workforce – *Living longer, living better Blueprint* partners

Below are workforce numbers that may potentially be impacted by the programme of change. As discussed, with the HR experts within the domain activities, there will be some groups of staff who are more directly impacted by the care models/s but also other staff that will be indirectly impacted by the achievement of the broader vision. For consistency of presentation the figures are standardised to include those roles and headcounts considered to be providing or supporting front line care delivery.

Staff Group	Headcount
Manchester City Council	
Adults Social Work and Primary Assessment	245
Children's Social Work and Specialist family Support	433
Adult Day Services	173
Homelessness Services	227
Learning Disability Networks	317
Physical Disability Network	36
Customer Access Services	52
Learning Disability Partnership Social Work Teams	37
Adults Safeguarding	9
Re-ablement Teams	178
Equipment and Adaptations Service	91
Public Health	50
Strategic Business Support (direct support of 'care' services)	108
Adults/Children's Commissioning and Performance Improvement	167
Fostering and Adoption	86
Children's Residential Staff	164
Youth Offending Service	66

Education and Skills	203
Early Years/Special Educational Needs/Safeguarding Improvement Unit	707
Sub-total	**3,349**
University Hospitals South Manchester NHS Foundation Trust	
Additional Professional Scientific and Technical	293
Additional Clinical Services	976
Allied Health Professionals	365
Healthcare Scientists	93
Medical and Dental	501
Nursing and Midwifery Registered	2,182
Students	8
Sub-total	**4,418**
Pennine Acute Hospitals NHS Trust	
Additional Professional Scientific and Technical	324
Additional Clinical Services	1,433
Allied Health Professionals	542
Healthcare Scientists	202
Medical and Dental	787
Nursing and Midwifery Registered	2,924
Students	13
Sub-total	**6,225**
Central Manchester University Hospitals NHS Foundation Trust	
Additional Professional Scientific and Technical	594
Additional Clinical Services	1,995
Allied Health Professionals	633
Healthcare Scientists	560
Medical and Dental	1,043
Nursing and Midwifery Registered	4,063
Students	45
Sub-total	**8,933**
Manchester Mental Health and Social Care Trust	
Additional Professional Scientific and Technical	184
Additional Clinical Services	542
Allied Health Professionals	50
Healthcare Scientists	1
Medical and Dental	59
Nursing and Midwifery Registered	495
Sub-total	**1,331**
Grand Total	**24,256**

Table 2, numbers of paid health and social care professionals in Manchester

There are additionally, 210 employees of the three Manchester clinical commissioning groups, making an overall total of 24,466.

It is acknowledged that at this stage there are caveats attached to the presented data. The figures do not fully represent shared core corporate support functions, they do not include apportioned administrative, estates or

ancillary workforce numbers, bank only/honorary staff, junior doctor trainees whose records are held by another organisation and staff for which the organisation is host employer/payroll only.

B3.1.4 Our city's care partners' workforce

We acknowledge that successful and sustainable delivery of our care model(s) is potentially impacted and enabled by other care partners with whom we need to engage further. By way of a very small example; there are 142 schools in the city employing circa. 6,699 staff, our city's general practices have a combined workforce which includes 395 general practitioners and 244 nursing staff (included practice nurses, nurse practitioners and health care assistants). The voluntary and third sector care partners make a significant contribution to caring for our people. And then 'our people' have an untapped potential to have a more positive impact on how long and how well they live. The number and range of care partners within the city is extensive as is the potential for redesign of our workforce to work within new delivery models.

B3.1.5 What we can build on and what we must focus on

The level of analysis related to the workforce information above presents an indication of the potential challenges and opportunities for developing a workforce that has the capacity and capability to be deployed with the right skills, in the right place at the right time within the city.

However we know we can build on this level of analysis due to the potential of the health electronic staff record and similar records within social care. With greater clarity emerging from the care model(s) we can analyse further the workforce impacted by the proposed changes. We can also utilise data analysis from networks such as the Workforce Information Network portal (eWIN). This provides access to health service workforce information with the ability to drill down on various workforce metrics. It can also support detailed workforce profiling and planning to inform the business case for change. Similarly the National Minimum Data Set for Social Care (NMDS-SC) [www.nmds-sc-online.org.uk www.skillsforcare.org.uk/nmds-scdashboards] will enable further profiling and information on the social care workforce.

This information will be critical to more detailed workforce planning for providers and partners as well as for workforce commissioners.

We believe that whilst the entire partner organisations workforce may not be directly impacted by new care delivery models we should be applying the principles within our whole workforce of the need to take steps to better influence and role model health promoting behaviours and providing support and incentives to do so. The sheer numbers of our combined workforce makes it a potentially significant role model for living longer and living better and therefore part of the social movement for the cultural change required in the city.

We will build on the strength of a diverse, skilled and well-developed workforce that has a good understanding of the local population and community relationships. There is a commonly held assumption within the partnership that the existing workforce is sufficient to meet future needs with appropriate redesign and deployment. We must learn from our experience and build on the success of redesign that has supported independence and well being, such as re-ablement, health trainers and our collective experience of integrating care programmes and partnership working to date.

We will utilise the strategic drivers affecting us. We will build on the strong city leadership for integration and the projects to date. The desire from service users for changing patterns of care delivery and the alignments this has with organisational long-term business plans.

The issues emerging from the workforce domain that need to be kept in focus throughout the next stage include those that exist in our individual workforce strategies; recruitment and retention difficulties in some areas, change and transition management, leadership and succession planning, high usage of temporary staffing (whether arising from the need to review commissioning, skill mix, support organisation development or plug gaps from unplanned sickness/absence), more proactive influence of inflexible and dated training programmes, assuring the quality and safety of workforce development, adherence to and influence of professional and regulatory requirements. We must also keep in focus the many contractual issues arising from any future needs to manage and deploy staff differently across different care settings and organisational boundaries.

B3.1.6 Likely areas for change and development

We believe integrating care that enables people to live longer and live better means better management of the interface between all those involved in the care system. We know the sequence needs to reflect the following:

- Defining/stratifying the target population
- Describing the preferred option for an evidence/assumption based care delivery model for the system and describing the elements within it.
- Analysing what this will mean for the workforce change
- Implementation planning (describing the plan for re-orientating the workforce and commissioning that of the future)

And that the likely change required will include the potential for:

- Alternative care givers
- Alternative care settings, and
- Alternative care processes

This will mean a move away from care pathways, dependency on services, role specific and ‘-ology’ focussed care. The future state will require a workforce equipped to work within care models, in partnership with people, organisations and communities. There will be: shared ownership of people

and needs, a problem solving focus and a holistic as well as targeted approach to treatment prevention and well being promotion. The workforce of the future will be less fixed to hospital buildings and it will be enabled to work more effectively and efficiently across organisational boundaries and with communities.

B3.1.7 Next steps and further development

The new care model(s) will drive the workforce strategy and planning. It is proposed that these are further developed collaboratively and in alignment with other interdependent workforce strategies.

We will work collaboratively as providers of services and with those who have roles associated with commissioning and developing our workforce. We will be more innovative in our approach to this. We will re think our existing approaches to workforce commissioning and planning. Workforce commissioning needs to be seen strategically across the city in a way that helps partners balance supply with demand. Workforce plans will describe how the partners and people of Manchester turn the aspirations of *Living longer, living better* into the practical reality of the workforce undertaking the roles and tasks required to deliver the desired outcome. This is not just an issue for employers and providers but it is about building our workforce in its widest sense. It is about developing skills in the community and equipping our people with the right skills, behaviours, competencies and attributes.

A formal baseline assessment of the workforce currently delivering elements of integrated care and those who may work in this area in the future will be carried out and this will include appropriate engagement with stakeholders. We need to understand our whole workforce characteristics in order to respond to the offer and outcomes within the proposed care model(s). We will identify the stakeholders based on the proposed care model(s) and carry out an analysis of the level and engagement approach required.

There is no current single workforce strategy within the city that is geared to the delivery of the care model(s). This will be required in order to facilitate a system response that will not only change the workforce of the future but will allow for the transition in the way the current workforce cares and is deployed. The challenge presented by such a large-scale workforce change is felt and we will establish leadership arrangements for the workforce commissioning, planning and redesign. This will either be by extending existing arrangements or creating new ones. This will enable a workforce strategy that sets out the overall vision and timed objectives for our workforce to be agreed. This will drive our organisations and communities in the management and deployment of our workforce to provide care for people with lives not patients with conditions.

We have a good level of understanding in terms of how the workforce operates within our care pathways and services. We are delivering elements of the models already, however, it is important we understand that care pathways are not care models. The care model will be based on outcomes

and offers to achieve those outcomes. We will undertake an impact assessment of the care model(s) to understand the gaps for the future state in order to take account of the anticipated shift in the workforce requirements. This will allow us to map out the change required.

We will then agree a workforce development plan based on full understanding of the competencies required to deliver the offer/s, this will in turn define the roles and the future workforce required. The plan will set out to address the transitional planning and future commissioning, for the workforce. The plan needs to address how the workforce is employed, deployed, commissioned and works together.

We will begin immediate preparatory work with key Health, Social Care and Carer networks to make early progress. This will include Health Education England (HEE) in order to inform its North West Health Education Northwest Workforce Planning and Education Commissioning Process for 2013/14 to 2017/18 and the Deanery (North West and Mersey). HEE has a role is supporting healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through development Local Education and Training Boards (LETBs). We will engage the LETB support team in moving forward.

Similarly the Association of Directors of Adult Social Services (ADASS) is working with Skills for Care on workforce commissioning[3]. We will pro-actively engage with this network.

B3.2 Our buildings

Blueprint statement
"To have quality buildings providing multi-agency co-ordinated care to support people to live longer and live better"

B3.2.1 Background

In order to develop our estates portfolio to provide well located, high quality accommodation that can be utilised more flexibly and provide services that are co-ordinated around the individual in a pleasant environment, we need to understand our current citywide estate provision and where the gaps are.

Across the city, our health and social care estates are provided by a number of organisations ranging from NHS Property Services Ltd to individual GP practices. The estate incorporates a varied range of premises and their distribution is uneven with differing levels of provision, effectiveness and resource.

The way that the estates are currently provided reinforces old organisational silos and a significant number of them do not provide effective accommodation. The current complexity of provision does not support the integration and development of health and social care estates and provision. Historically commissioning strategies have not always driven the supporting estates strategy; going forward it is essential that they do.

This chapter will describe the current estates management arrangements across health and social care and will go on to map out where our estates are located and where the potential is to provide integrated estates provision in the future. For the purposes of this paper, primary care will relate to primary medical care (GP) usage. In order to establish an initial baseline of our estate, community pharmacies, dentists and opticians have not been covered; however it may be beneficial to include consideration of these providers in the future. The type, location and nature of the estates provision that will be required will be determined by the *Living longer, living better* care model and population. A summary of our current estate is provided at appendix B6.

B3.2.2 Current estates provision

Healthcare-related estates.

In 2013, Primary Care Trusts and Strategic Health Authorities were disestablished and their commissioning responsibilities were devolved to a number of receiving organisations including NHS England (within Area Teams), Clinical Commissioning Groups and Local Authorities. The transfer of the PCT and SHA estates function (ownership and facilities management) were distributed as follows:

NHS Property Services Ltd (NHSPS)

NHS Property Services Ltd is a new private company wholly owned by the Department of Health that has taken over the ownership of all the PCT and SHA legal interests in non-LIFT premises. These can range from GP practices and Health centres to administrative buildings, all of which constitute the great majority of PCT and SHA premises. All PCT estates and facilities staff transferred to NHSPS.

NHSPS work closely with the NHS England Area Teams and provide~~s~~ a central pool of estates expertise that can support the local commissioning teams including CCGs.

Community Health Partnerships (CHP)

CHP are responsible for facilitating public and private partnerships and ensuring, in conjunction with NHSPS, that health commissioning drives strategic estates decisions. They took ownership of the PCT's responsibilities in the Local Improvement Finance Trust (LIFT) programme, inheriting the PCT shares in the LIFT company and became head tenant for the NHS LIFT buildings. It should be noted that LIFT companies still retains its' exclusivity

status for any NHS estate development within Manchester. CHP which has the same ownership arrangements as NHSPS, is recognised as a sister company to NHSPS.

NHS Foundation Trusts

NHS Foundation Trusts had the option to take ownership from PCTs of the interest in existing community facilities, where they their clinical services occupied more than 51% of the floor space. In practice not all Foundation trusts exercised this right and most of the premises transferred to NHSPS. One example whereby ownership of health care premises transferred to a Foundation Trust is in South Manchester where Withington Community Hospital transferred to UHSM.

Primary Medical Care premises

The citywide profile for primary medical care premises, present a complex picture. The funding for accommodation of GP practices is determined by the NHS (General Medical Service Premises costs) and reflects the fact that practices may be private tenants, tenants within NHS owned premises or owner occupiers. Most GPs consider their premises to be primarily for the services that they provide. However, there are a significant number of instances across the city where GP Practices have accommodated supporting services on a sessional basis. These arrangements have rarely been formally recognised or have any financial recharge.

Social care-related estates.

Corporate Property (an internal department within corporate services of the Local Authority) acts as corporate landlord and provides an advisory and support service to directorates. The corporate landlord model works on the basis that notional leases are created with Council Directorates to occupy premises, with SLAs for supporting services.

Independently-owned premises.

There are a number of premises utilised by health and social care across the city which are owned by independent landlords and leased (comprehensively or sessionally) for use by our services.

B3.2.3 Future estates provision for *Living longer, living better*

Despite the fact that public sector services are delivered out of many and varied premises across the city under relatively complex arrangements, our estates will need to be developed and integrated in order to support the delivery of our living longer, living better population and care models.

In the future our workforce will be supported by technology to enable them to work in a much more mobile way than they currently do, so that they will provide care where a person lives – in their home or in the community, but not

necessarily within an organisational location. We will support our citizens to travel to one base where they can access all their health and social care needs in a place that is convenient to them and in a pleasant and accommodating environment. As a result, we may require fewer sites than we currently have that are more intensively utilised. Our sites may be required to provide a health and social care campus which may include services such as pharmacy, diagnostics, housing and primary care. These may be provided out of a smaller number of larger facilities.

Our premises will need to be utilised more flexibly in order to support a mobile workforce and to enable our services to provide an offer of 24/7 care to our patients. Services within our facilities that have been traditionally provided Monday to Friday in core hours may be provided during the evenings or earlier in the morning. It is expected that there will be more services provided over the weekend. In order to support a different culture of service provision on a 24/7 basis, a hub-based estates model, where the hub provides greater access to integrated services for patients requiring intervention and support and also supports a smaller number of locality facilities may be favourable. We want our facilities to be utilised as a local hub for local groups and residents in the community and for them to feel a pride in the facilities in partnership with the services that are provided from them.

Equipment that may have been traditionally provided in hospitals may be provided closer to home in the future; our premises need to be able to adapt to that and to supporting equipment usage at home, for example with tele-health. Some services could be provided in less traditional health environments in order to target specific population groups, for example leisure facilities, libraries or colleges.

Our integrated teams will work as one co-ordinated workforce, and our estates must also be integrated across health and social care to provide the highest quality and most accessible buildings. To support this, our estates need to be provided at a higher specification than they currently are in terms of their flexibility, usage and surroundings.

B3.2.4 Location

As part of the estates domain work, a citywide team have populated a ‘visual’ map which sets out collectively where our facilities are spanning community health, primary care (GPs), mental health and social care. The map, which is printed at the end of this chapter (individual copies available from joanne.royle@uhsm.nhs.uk to enable closer study), provides the detail that was collected in order to do this. This is a simple overview of our estate, however it provides a solid baseline for future analysis. Reviewing the current locations and funding arrangements for our estate will enable the future development of our estates strategy, wrapped around our care model.

The ‘visual’ demonstrates where there are areas across the cities that do not appear to provide as much physical access to services as other areas. Examples include Wood House Park and Charlestown. In order to

understand the impact of these, and other, observations a further analysis of patient need and other local services such as public transport will be required.

There are a significant number of locations where we already provide multiple services across organisations. Theses sites may provide opportunities for further development in the future dependant upon location and patient need determining that the facility is situated in the most appropriate place.

B3.2.5 Commissioning of estates for the future

It is clear from the scoping work undertaken so far that our estate will require a level of reconfiguration in order to support and enable the *Living longer, living better* programme to succeed and for our services and staff to work in a truly integrated way.

In order to gain maximum utilisation of our estates assets we will need to bring together health and city council estates. Primary care estates have previously been largely viewed and treated as separate stock, but we must include them in this joint work in order to gain maximum efficiency of our sites. In the past, commissioning of services has not driven our estates strategy. We need to work together to develop our estates strategy in a more joined up way.

Our next steps will need to focus upon our neighbourhoods, with a full needs analysis undertaken of all our estate across health and social care, building upon our initial scoping of estates, to identify where we have an ability to generate our assets by identifying sites with a long term value and also where capital can be generated by assessing sites that can be disposed of. We need to maximise the sites that we wish to maintain to support *Living longer, living better*. Part of this exercise will be to identify the best and most accessible places in our communities, from a patient and people perspective, for our sites to be. We need to overlay the care requirements of our population to identify where the best estates solutions should be developed. As part of this work we will need to determine the model of estates provision. Much has been covered in this chapter about the need to provide multi services in appropriate locations; however this will need to be balanced with the need to provide services that still feel local and personalised to the individual, where clinicians are supported to maintain a working relationship with their patients.

In addition to our finance and contracts work supporting the development of our investment models for services, we also need to develop our investment model and strategy in relation to our joint capital assets. This would include our low value assets being supported by high value assets, and ownership being related to level of investment rather than organisational boundaries. This would be for the finance and contracting workstream to develop, however, to support that work it is imperative that a needs analysis enables us to provide a clear strategy for how our buildings should look and function in an integrated way, and how they will enable our workforce to deliver *the Living longer, living better* care models in an effective and efficient way.

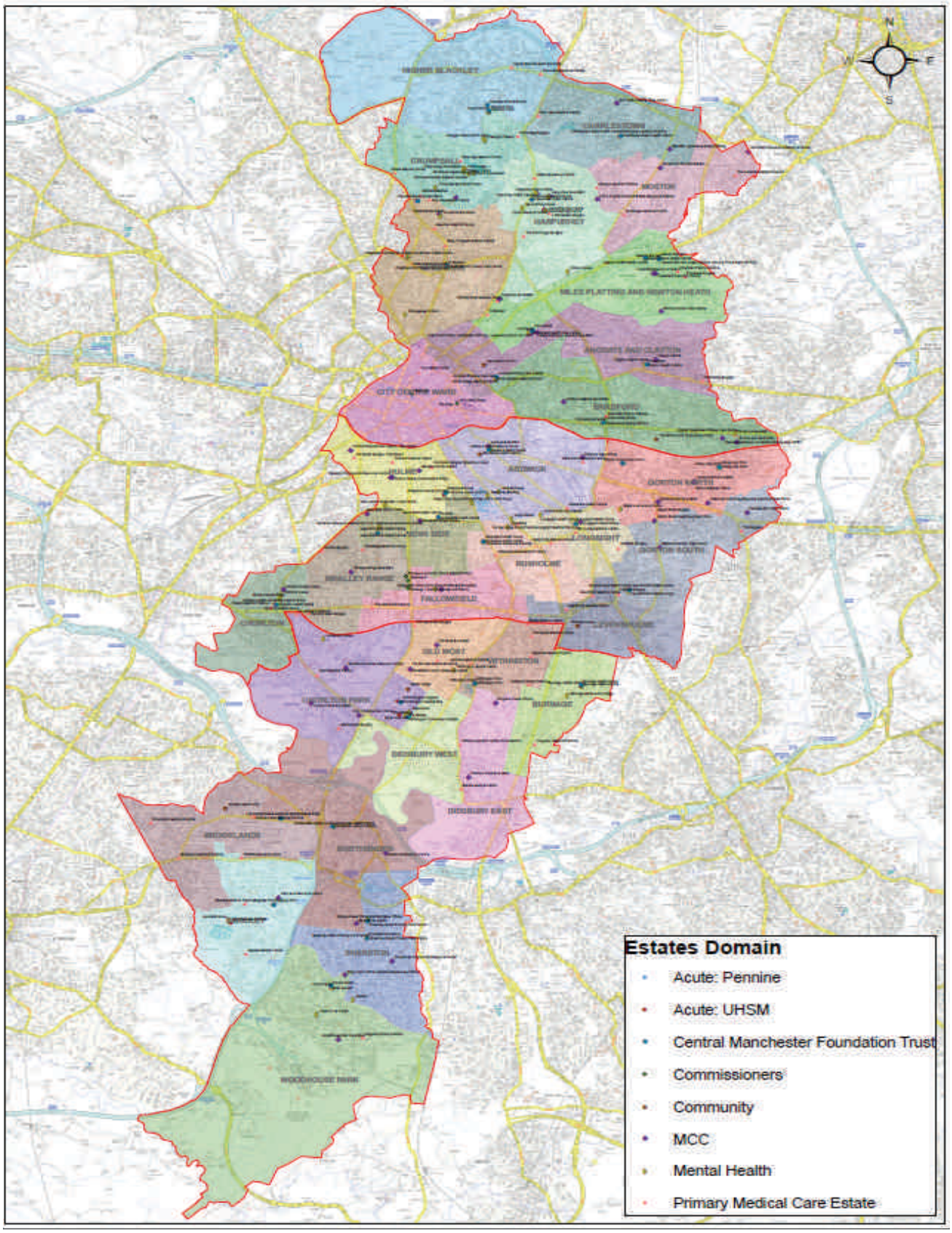


Figure 1, health and social care estate across Manchester

B3.3 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."

B3.3.1 Introduction

Integration is the approach by which we want our future care model to be centred on the person. This means that our Information domain must also be citizen-centric, and we must equip our workforce to provide the best health and care system for Manchester people. Good information is the basis for genuine shared decision making with patients and citizens. Good information also enables our workforce to make care delivery safe and more efficient.

- Information, Management and Technology (IM&T) encompasses all of the IT equipment, systems and data that we need to underpin our new care model. It includes:
- Operational solutions to support staff working with patients, carers and families,
- Information delivery solutions for citizens, patients and our workforce, Population analysis tools to look at whole system outcomes
- Performance management tools to support service improvement and management.

B3.3.2 External strategic drivers

There are a number of national drivers which recognise that information is a critical factor underpinning a world class care model and care system:

- *Liberating the NHS: An information revolution* (London: Department of Health, 2011)
- http://www.ico.org.uk/about_us/consultations/~/media/documents/consultation_responses/Liberating_the_NHS_An_Information_Revolution_Consultation.ashx
- *Putting patients first: the NHS England business plan for 2013/14 – 2015/16* (London: NHS England, 2012)
- http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf
- Digital First http://digital.innovation.nhs.uk/pg/dashboard
- NHS Digital Challenge http://digitalchallenge.dh.gov.uk/
- *Information: to share or not to share? The information governance review* (London: Department of Health, 2013)
- https://www.gov.uk/government/publications/the-information-governance-review

B3.3.3 NHS England technology fund

On 22 May 2013 NHS England announced the launch of a £260m technology fund. The fund will be become available in June 2013 and expressions of interest for the fund are expected to be submitted by the end of July. The fund will be available to NHS providers to support the introduction of electronic care record systems, and the linkage of electronic patient records across providers. This national initiative is an opportunity for Manchester to seek significant capital investment in technology and information systems to enable the *Living longer, living better* strategic aims.

B3.3.4 Current 'as is' state – where are we now?

A high-level analysis has been completed of the IM&T domain across health and care in Manchester. The current systems architecture for health and care is extremely complex, fragmented and to a large extent focussed on specific pathways or patient/customer groups.

Our hospitals use a large range of systems with some interoperability and integration within each acute organisation. However, there is generally poor availability of clinical information (but good availability of data with regard to activity such as tests and results etc., through patient management systems). Patient records are still largely paper records, and all three acute trusts are progressing procurement and implementation of electronic document management systems to start to address this issue. A significant gap for the whole of Manchester is lack of a clinical records system for community health teams and lack of appropriate technology such as mobile solutions to free up more staff time for patient contact. Mobile working is already being trialled with some staff groups and there are local strategies and plans for the immediate future, regarding IM&T deployment, which will likely address some of the needs of the *Living longer, living better* programme.

GP patient record systems already use a standard dataset which enables the transfer of information between practices. It is estimated that by 2016 more than 90% of Manchester GPs will be using the EMIS Web system. The GP systems can be developed for use across other clinical areas, and an example of this is the UHSM cystic fibrosis team is starting to use EMIS Web for its clinical recording. Patient access to clinical records, appointment booking and prescription requests using mobile devices (smart phones) is being explored by some practices.

At Manchester City Council there is a core system (Frameworki) for recording social care information for adults and children referred into services. There are also some peripheral systems for particular areas such as the Supporting People programme and Children's Special Educational Needs for example. Mobile working for assessment and social work staff is planned to be implemented in the next 12 months.

Manchester Mental Health and Social Care Trust has a single clinical records system (Amigos) and increasing remote access for community teams is

required and being started this year. It is also recognised that the system has its limitations and it is anticipated that it will be replaced in the next few years.

B3.3.5 Key strengths – what can we build on?

Manchester already has a wealth of systems, technologies and data, all of which could be more effectively utilised to meet the needs of our citizens and workforce. IM&T must focus on building on what is already working at small scale and sharing good practice across the city (and beyond to Greater Manchester and nationally / internationally). We must look for opportunities for wider adoption of existing, already proven IM&T solutions, and implementation of strategies to integrate technologies and data, harnessing and driving forward with the impetus from achievements so far. This must be done in the context of each organisation's existing IM&T strategy and programmes of work already in implementation/design.

There are a number of foundation elements for our IM&T strategy that are already in place. NHS Number is our primary patient identifier across all health and care systems, which will support the aggregation and delivery of person centred information. We have made good progress around the Information Governance (IG) agenda with health and care IG governance leads from across the city signing up to an over arching IG protocol. A clinical super portal is being developed for Greater Manchester and Cheshire which will enable different providers of care to view patient information stored in other providers patient records systems. This is already in place and working at The Christie and Wythenshawe hospitals. We already have one data warehouse (for health) in Manchester which can be expanded and further developed, and there are significant data warehousing skills and infrastructures across our health and care organisations.

There is a growing appetite amongst citizens for technology solutions around health and care. We must build on this enthusiasm and also engage with our world-class universities and medical schools to bring new innovations and thinking to how we support people in our future care model.

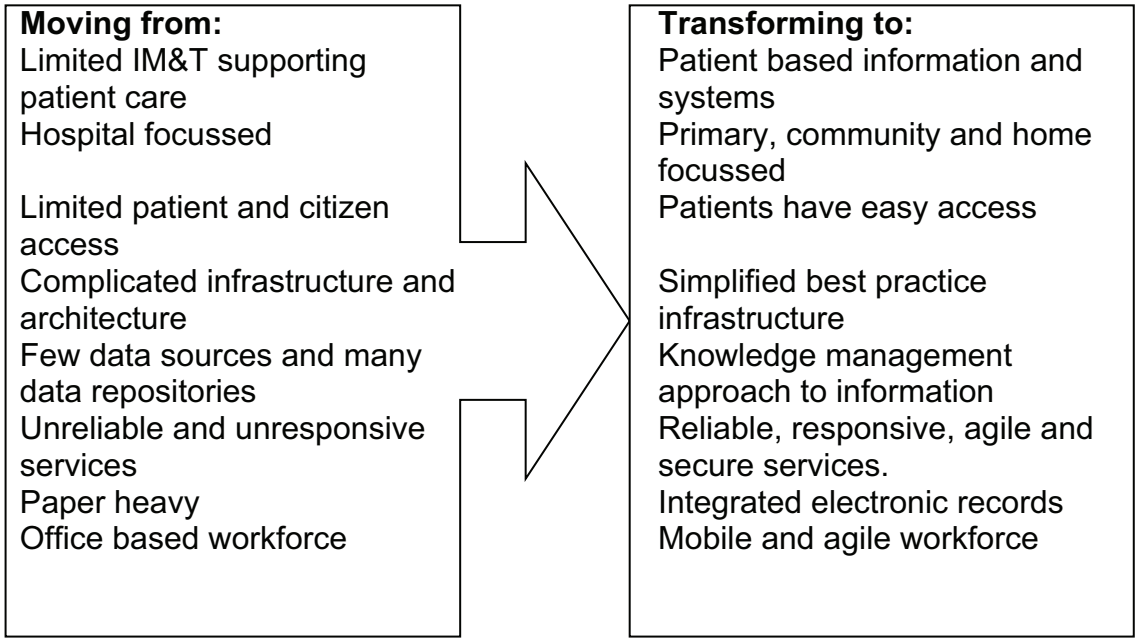
B3.3.6 Key gaps – what do we need to focus on?

The biggest identified gap in the IM&T domain is a clinical records solution for community health teams, including the availability of physical equipment (mobile devices and capability etc., to improve effectiveness and efficiency of our services). To save costs and increase capacity we could better enable sharing of equipment so staff from different health and care organisations can use each others kit already available in offices to access patient records for example. If equipment sharing is going to be enabled then agreements will be needed between organisations with regard to IM&T support and helpdesk functions for example. Further more detailed analysis is required as to what is and is not being used where, such that appropriate decisions and balance can be made between sharing existing infrastructure and the creation of a new mobile working based infrastructure.

A number of issues regarding the scope of work need to be tackled. It must be ensured that whatever is developed for infrastructure, systems or data analysis can support purposes beyond *Living longer, living better*, and are transferable to other areas of core business. There are lots of systems already being used which have different footprints (geographical stretch, population groups etc.). If we develop our data analysis capability really well we will find unmet need in our Manchester population which will require additional capacity and resource, therefore we must be really clear about the scope of data uses and the implications.

Whatever we develop in the future in our IM&T domain must be citizen-centric. We must properly engage Manchester people in the debate, discussions and decisions on how we develop and deploy new technologies to support our integrated care model.

B3.3.7 IM&T of the future – how will it be different?



B3.3.8 Next steps – what will we do now?

- Based on the proposed care model, target population and overall timescales, we will develop an IM&T strategy for *Living longer, living better*, building on the core principles identified already – building on evidenced good practice, integration of data and systems, citizen-centric.

- We will engage with our Manchester population to be clear on IM&T priorities and requirements for integrated care from a citizen's perspective.

- We will consider how information governance requirements impact on the work and address them in our work plan.

- We will start work with our universities, colleges and medical schools to promote innovation in our health and care IM&T sector.

- We will carry out an impact assessment of our capability and capacity to deliver what we need in terms of IM&T and develop a costed implementation plan including external resources and support as appropriate.

B3.4 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."

B3.4.1 Introduction

This chapter describes how there should be a whole system approach to delivering the care model(s) as outlined in the 'our care model' chapter. This chapter provides an introduction to this subject; further work will commence following approval of the strategic outline case.

The needs of the population will be met by a system that works collaboratively. This will require the six commissioning organisations outlined in A3.3.10 to work more closely together to ensure a coherent requirement of the system in meetings the needs of people at a local level.

B3.4.2 Commissioning new care model(s)

Commissioners will need to describe expectations and requirements of the system in the delivery of the new care model(s) that are responsive to need and delivered in the context of understanding the communities and cultures people live in. Commissioning a system that delivers the care models has to be based on a set of guiding principles that are focused on:

- Responding to the needs of the local population
- Building independence and reducing reliance
- Enabling self-care
- Commissioning for outcomes rather than for individual services within individual organisations

B3.4.3 Systematic approach to the delivery of new care model(s)

It is important to state that the delivery of the care model(s) is fundamentally about a **system** response **(not organisational**) to deliver. The system would

need to work within the guiding principles, as well as collaboratively to meet the agreed goals and outcomes described by commissioners.

The system would need to operate within agreed thresholds in order for people to receive a consistent and time response to service access and treatment, advice and guidance. The system will need to be flexible in its response to meeting changing need at a local level.

System behaviours will need to focus on the goals of helping people in Manchester to live longer and better, along with delivering the agreed outcomes as described by commissioners. Risks, issues and achievements will be owned by the system, and the system will work collectively to manage and resolve risks in order to deliver the agreed goals.

B3.4.4 Evidenced-based interventions

We need sound evidence-based interventions that improve health, reduce risk, enable self-management, and promote better management of care within communities.

The models of care will determine the evidence-based care offer that should be reflected across the city. Localities might do different things in different ways in different orders, responding as they do to local issues including boundary flows and specific local service developments. The system has started to test evidence outcomes at locality levels for high and very high risk stratified customers and we can agree quickly a transitional scale up for these areas. The focus needs to be on moving the out of hospital flow and manage care in the community will require a shift in resources to enable a response time with a community.

B3.5 Public engagement for better health and wellbeing

***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."

B3.5.1 Introduction

This report outlines how we are going to develop a health and social care system in the city which is integrated, provides high quality, effective care, and is supported by modern technology and facilities. However, our ultimate aim is to support people to live longer, healthier lives and this will not be achieved by simply reorganising where and how care is provided to those who

fall ill. We believe that the biggest impact to the health of our population will be made if we can work in partnership with our residents, within our communities, and in a co-ordinated way, to promote and support healthy lifestyles and change current behaviours.

To do this, we need a public engagement programme that is not just about informing but involving. We need to move from traditional ways in which we have communicated as individual organisations to a programme of engagement which works with the assets which exist in our communities and drives the change required both in local services and within our population. For too long, Manchester has languished at the bottom of the league in terms of health statistics. *Living longer, living better* gives us an unprecedented opportunity to change this, creating a city whose residents aspire to, and expect, good health, and health and social care organisations which enable them to achieve it. This ambition is not new. What is different this time is the recognition that the solution to poor health lies within our communities, not within our organisations.

B3.5.2 Where are we now?

Healthy communities

Public Health Manchester commissions a range of programmes and services that aim to promote healthy living and develop healthy communities. The majority of these are provided by Manchester Mental Health and Social Care Trust, with others directly provided from within the Council's neighbourhood services. As a result of historical funding arrangements, some of these services are not provided in a uniform way across the city. In addition, they are sometimes not sufficiently connected to the way other NHS and social care services are currently developing.

Self-care

Public information to improve the ability of individuals to safely treat minor ailments at home has largely been campaign-driven, centred on the national Choose Well campaign and using local media to put over key messages. More focussed work has been carried out to support people with long term conditions to better manage their conditions. This includes simple information provision, self care courses (e.g. Expert Patient Programme), condition-specific, self management courses such as those run by Diabetes UK, and patient-led support groups. Increasingly, technology has an important role in supporting self care and tele-health pilots are being undertaken across the city.

Communication

Each of the partner organisations has established communication channels which they use to disseminate health and well being information, deliver campaigns, and promote and publicise the services they offer. These may be place-based (e.g. clinic waiting rooms), digital (e.g. websites, social media),

publications (e.g. newsletters, e:bulletins), outreach (e.g. community events), face to face (personal advice from health workers/social workers) or media focussed (e.g. BBC3's Unsafe in the City which is based around sexual health services at CMFT). Apart from a small number of examples, there is little co-ordination between partner organisations when it comes to delivering public information or organising campaigns. In addition, we have an insufficient understanding of what other communication channels exist within communities and how they can help support promotion of health messages.

Public/patient engagement

Partner organisations have also developed their own mechanisms to involve the public in the decision making of their organisations. These can be 'membership schemes', patient/public groups and committees, voluntary sector networks and community guardians or, in the case of Manchester City Council, local councillors and ward co-ordination groups upon which their democratic process is founded. Often, the same individuals will be members of a number of these. In addition to these structural elements, each organisation involves patients and service users in the planning and design of specific services, as well as using feedback from individuals and communities to monitor and improve the services they provide. A range of methods are used to do this, effecting real improvement in services, but learning arising from engagement exercises is rarely shared between organisations and not necessarily between services in the same organisation.

Alongside agencies' structures and methods, Healthwatch Manchester has a specific, independent role to collect local people's experiences and preferences for local services and to use them to drive change and improvement. Managed by the Citizens Advice Bureaux, Healthwatch Manchester was formed in April 2013 and is therefore in its early stages of development.

Voluntary/community sector

Manchester has a diverse range of voluntary and community sector organisations, community-led assets which have great potential to support this programme. Some deliver clinical and non-clinical health and social care services under contract from statutory organisations, whilst others receive grant funding from a range of sources to deliver their aims. Despite some joint work, engagement with the sector is patchy across the city and a number of voluntary organisations have found current austerity measures across the public sector are affecting their ability to attract funding.

Personal budgets

The last few years have seen the debate around personal involvement in care planning taken to a new level with the introduction of direct payments, individual budgets and personal health budgets. These programmes provide the service user or patient with their own budget to allocate according to their personal needs.

The city

As a city, Manchester has thrived over the last 20 years and is now widely recognised as the second city in the country. National and multi-national businesses have moved to the city, the physical landscape has been transformed through regeneration programmes, and the city's sporting and cultural sectors continue to break new ground in terms of achievement and innovation. The Manchester Partnership and Manchester Board provide a forum to consider how public, private and voluntary sector organisations can work effectively to further the city's development.

B3.5.3 Where do we need to be?

Our residents

We need to work within our communities to create an environment where local people:

- Prioritise their health and wellbeing
- Come up with their own solutions to long-standing health issues
- Act as peer to peer 'agents of change', providing information and supporting healthy lifestyles in their communities
- Design, and choose, the services they need to support them to live independent, healthy lives
- Can easily access the support they require when ill and when seeking to improve their health and well being
- Are provided with the skills and equipment to safely manage their long term conditions
- Understand what services are available to them and when, and how, to contact them
- Are supported to care for their families, loved ones and neighbours

Our services

We need to develop services which:

- Listen to service users and evolve as a result of their feedback
- Support people to live independently and manage their conditions safely
- Are known within the community
- See every touch point/appointment as an opportunity to promote good health

Our organisations

We need partner organisations that:

- Identify, recognise, invest in and support those community based 'assets' which can promote good health and effect change within their neighbourhoods
- Offer open access to data and information, within the terms of statute and existing guidance
- Develop common standards and approaches to service provision focussing on empowering patients and co-design of services
- Encourage staff to come up with ideas of how to improve services or better support patients and carers
- Co-ordinate public information, public engagement and campaign work, sharing communication channels and engagement mechanisms where it makes sense
- Deliver a city-wide programme, founded on a strong evidence base, which focuses behaviour change work according to the different needs of the target populations identified under *Living longer, living better*. This should focus on fewer campaigns being done well as opposed to a large number of campaigns spreading resources too thinly and bombarding the local population with a confusing range of messages

Manchester

As a city we need to:

- Identify opportunities to work across all sectors to improve health and well being
- Harness the skills within all of the city's assets to develop a healthier city
- Actively seek out opportunities to bring money into the city to improve health and well being
- Ensure staff and the public are aware, understand and support the new health delivery models

B3.5.4 How do we get there?

The transformational nature of the vision outlined above represents a significant undertaking for the partner organisations and will challenge existing ways of working. It will also challenge communities in the city to reject the status quo and aspire to better health and wellbeing. It is this 'disruptive' nature of these proposals that marks a difference between this approach and previous attempts to build a healthier city. Such an approach is, however, challenging. Organisational and community cultures will not change overnight and there are some aspects which will take some time to plan, implement and show impact.

The key enabler for this social and cultural change we are striving for is the review and redesign of Healthy Living Services being undertaken by Public Health Manchester in 2013. At the heart of the redesign will be a focus on using and supporting the assets within our local communities to promote

healthy lifestyles, deliver behaviour change campaigns and co-design health and social care services to better meet the needs of communities.

Whilst this work is being undertaken, the following will be carried out:

- Mapping, and sharing, of communication channels and public engagement mechanisms between partner organisations to achieve better co-ordination of public information
- Understanding current 'as is' communication and engagement resources – budgets, skills, people and highlighting strengths and any gaps/ issues in resources that could impact delivery of the 'to be'
- Review of what has worked to date – gather any evidence from communication and engagement activity that has worked in Manchester and proven to improve health, wellbeing and/or change behaviour
- Supporting and understanding the 'audience' with support from data and population analysts
- Undertaking an evidence-based assessment on what campaigns have worked, nationally and internationally, on key health priorities and applying this learning to a Manchester context
- Planning, prioritising, and beginning delivery of, a co-ordinated programme of health and well being related campaigns across all partners. These will be targeted on the segments of the population outlined in the 'our people' section of this report, will tackle priority health issues and will be tested, fully measured and evaluated. This will lead to a number of campaigns focussing on the vast majority of the population alongside some more targeted campaigns targeting those with higher health needs.
- Evaluation of existing integrated care pilots using patient/carer diaries and structured telephone interviews
- Involvement of patients and carers throughout the *Living longer, living better* programme are identified. This will be in the structure of the programme itself as well as within the delivery of specific domains
- Full review of the way in which public health communications are undertaken across the City Council and Public Health Development Service to ensure that such communications are strategic, co-ordinated and maximally effective.
- Support the developing *Living longer, living better* health and care delivery model as it is established, communicating both internally to staff and also external to residents about the changes.

B3.6 Our leadership

"Leadership is about connectedness through shared vision, co-ownership, co-design and empowering partners in implementation"
(2008, Alimo-Metcalfe B., *et al.*)

B3.6.1 Shared Leadership

Introduction

If we are to build a new system of health and wellbeing and prevention/early intervention (as opposed to sickness and treatment and reactive responses) a whole system that works holistically for citizens and families at a neighbourhood or place level, we will need a new leadership approach. We will need "leaders whose actions are grounded in literature-based theory and who have a mental model for how the large-scale change journey typically unfolds ..... In order to facilitate change at the scale and pace now required" (NHS Institute, 2011)

The leaders of the new world in the context of public sector reform need to be able to work upwards, outwards, horizontally and vertically in their own and others organisations. To build a successful new leadership approach locally in Manchester City, the *Living longer, living better* strategic outline case and its leadership domain will explore and use several routes to prioritise next steps. These steps include:

- To describe the leadership we are looking for that will take us through the next five years and beyond.
- Use the latest research and learning from both Kings Fund and the health family, and the National Skills Academy and social care sector to inform our approach
- Use the knowledge, wisdom and inspiration freely shared by local and national leaders across health and care, private and public sector. (via roundtable discussion)
- To explore any formal leadership development which might, if experienced together, provide useful support for leaders across health and care (the NHS have recently released a suite of new leadership development programmes)

B3.6.2 Leadership within the workforce domain of the strategic outline case

This domain for the strategic outline case is not included in the workforce domain but they are interdependent and they both have significant workforce planning issues, tensions between specialisms and generic '-isms'. All workforce and leadership development requires engagement and empowerment with teams and managers but also requires leaders to be

accessible and visible, connecting with people and gaining insight into what will make a difference on culture, costs, quality and outcomes.

Leadership versus management

We are looking for leadership not management and leadership which influences and connects others. Currently, there is a familiarity with "management" which could be understood by its opposing characteristics to leadership i.e., a manager role relies on control of resources and processes to achieve its purpose, is dominated by directing and controlling resources and is defined by position in the organisation structure.

Leadership on the other hand relies on influence to achieve desired purpose and its authority is drawn from commitment of its followers. Followership is important. "Followers will allow themselves to be influenced when they see and admire a cause or vision." (Grint and Holt, 2011)

The Kings Fund (2012) in a piece entitled "Leadership of the whole system" identified characteristics required for working across the whole system and they are:

- Go out of your way to make new connections
- Adopt an open enquiring mindset, refusing to be constrained by current horizons
- Embrace uncertainty and be positive about change - adopt an entrepreneurial attitude
- Draw on as many different perspectives as possible, diversity is non optional
- Ensure leadership and decision making are distributed throughout all levels and functions
- Establish a compelling vision which is shared by all partners in the whole system
- Promote the importance of values - invest as much energy into relationships and behaviours as into delivering tasks

These characteristics could be used as competencies and leadership qualities that we can measure to support progress and personal development.

B3.6.3 Leadership in the social care sector

The Department of Health and National Skills Academy (2013) identified six key values and they are:

- Integrity (leading with honesty & conviction)
- Dignity (mutual respect)
- Compassion (caring & valuing)
- Support (praising effort)
- Growth (developing people)
- Principles

They go onto translate the principles of leadership practice into:

- Social purpose
- Co-production
- Innovation
- Improvement
- Integration
- Risk and responsibility

B3.6.4 Collaborative and community leadership

Collaboration means sharing with others and sharing power and control across systems and services .Integration at multiple levels is a key leadership challenge and where having a shared common purpose is integral to successful partnership.

Evidence indicates that collaboration, within and between organisations, gives greater flexibility and strengthens resilience (Shalk and Curseu, 2010)

There is also a need for real engagement with communities and for us to think through how we get the bottom up input from neighbourhood level and the top down leadership on the vision and common purpose so that community leadership operates to benefit place. Community budgets harnesses community leadership by better use of all resources across all stakeholders at a place level, sharing local knowledge and being asset focussed in order to create overall a unified approach for a place. They bring together partners across place into different governance arrangements. The statutory Health and Wellbeing board reflects this in its collective strategic leadership of the key priorities for health and wellbeing and for place.

B3.6.5 Systems versus organisations

The new leadership needs to understand a little about what systems are and how they operate.

The Kings Fund uses a definition of an organisation as a basic starting point as "a self contained entity where there is some degree of freedom insulating it from direct control from its external context." (Kings Fund, 2012)

In contrast they define a system as " an interconnected and interdependent series of entities, where decisions and actions in one entity are consequential to other neighbouring entities.“ (Kings Fund, 2012)

The Kings Fund (Leadership of whole systems, 2012) identify four distinct types of system: networks, markets, collaborations including partnerships and social movements. In our leadership domain it is important to consider what type of system we are trying to work in together and what we need to do to be successful within this system.

If we are leading collaborations, as leaders we need an agreed clear and compelling shared vision and a collective mandate and to accept that the goals that result are bigger than each individual and their organisation and that control over the outcomes is owned by all parties. The integrated teams that are delivering joined up care and support will need to have a common purpose and work across organisational boundaries but will also need to balance up their organisational constraints.

Public sector and particularly health and social care is often described as a complex adaptive system. Knowledge about the latter is important in our current public sector reform work and in our systems leadership around integration because all the literature refers to two important characteristics and they are:

- complex adaptive systems adapt to the particular state they are in and
- the system itself learns from experience and adapts to the whole system. This learning and knowledge changes individuals' behaviour.

B3.6.6 Leadership of public sector reform and its large-scale change

The reform across health and care, its implications across its systems, the necessary mind shift across workforce and the public requires leadership of large-scale change.

NHS Institute defines large-scale change as "the emergent process of mobilising a large collection of individuals, groups and organisations toward a vision of a fundamentally new future state, by means of:

- High leverage key themes
- A shift in power and a more distributed leadership
- Massive and active engagement of stakeholders
- Mutually reinforcing changes in multiple systems and processes (NHS Institute, 'Leading large-scale change', 2011)

The NHS Academy suggests that in order to achieve strategic goals, leaders need a grounded theory in large-scale change to make them more confident, competent and effective (NHS Institute for Innovation and Improvement, 2011)

Large-scale change is described as having three dimensions and they are:

- Widely spread across geographical boundaries, multiple organisations, or multiple distinctive groupings
- Deeply challenging to current mental models and ways of thinking (it feels uncomfortable and evokes some push back from others because it is so different from the usual)
- Broadly impacting on what people do in their lives or time at work and requiring co radiated change in multiple systems (Leading large-scale change, 2011)

Frances Westley (2002) highlights four venues of leadership:

- Bureaucratic process (manage in to navigate the bureaucratic process)
- Political process (look up hierarchically to the political process)
- Adaptive action process (work through the adaptive process of action and reflection)
- Community process (reach out in cultivating relationships and partnerships)

The leadership role is to juggle these four venues.

B3.6.7 Summary of the key leadership themes

In order to work holistically across health and care and to lead large-scale change we need:

- a distributed leadership approach
- new skills and competencies discharged
- leadership across geographical boundaries and complex systems
- lead at scale and pace

We need to develop this new leadership approach together across health and care at a place level.

The next steps for this section of the strategic outline case is to take the research on leadership and translate it into new ways of working, explore further some formal joint development, encourage increased access to leadership masterclasses via North West Employers, consider how the pooling and sharing of existing leadership offers, knowledge and expertise can be utilised to support *Living longer, living better* and its associated practice. This approach should support the city's implementation of integration of health and care underpinned by new care models and new investment models.

B3.7 Evaluating our progress

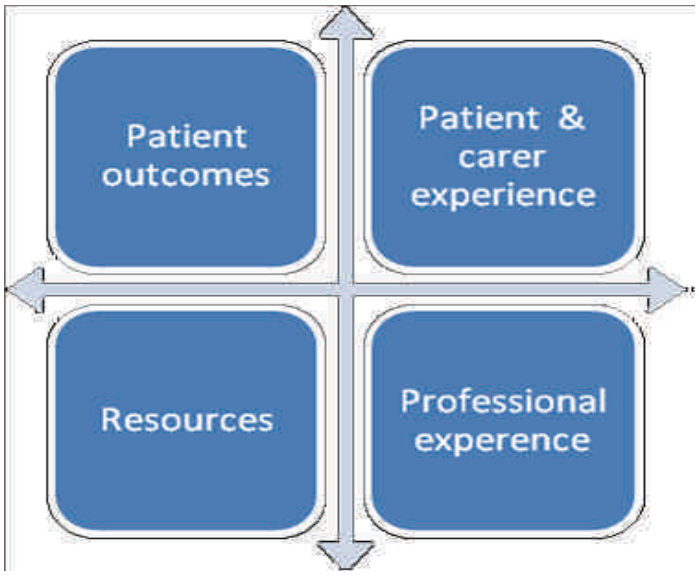
"Good evaluation is key to understanding whether the change programme is delivering its objectives. Good measurement and reporting will give confidence to decision making, aid design and ultimately determine whether the programme created a better system for the people of Manchester or not."

B3.7.1 Introduction

The *Blueprint* document develops this further to set out the aim of evaluation:

- 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 process 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.

Four domains are referred to which will need to be considered as part of the evaluation (see below)



Subsequent to the production of the *Blueprint*, further consideration has been given to the evaluation of the programme and the areas to be covered.

B3.7.2 Evaluation methodology

There is an extensive evidence base and information available from which to develop a detailed evaluation methodology for the *Living longer, living better* programme and this is amply articulated in the Kings Fund and Nuffield Trust's report: "A report to the Department of health and the NHS Future Forum – Integrated Care for patients and populations: Improving outcomes by working together".

Where it states *inter alia*:

> "It is important to define the ambitions and the goals of integrated care and to translate these into specific and measurable objectives. Making a compelling case for integrated care, both as a national policy and in terms of care redesign and delivery, is essential if people are to understand why it is being promoted as a priority".

The *Blueprint* document is clear in its ambition that the aim of integrated care 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".

The domain working group was cognisant of the need for a set of programme objectives in order that each of the other domains can develop their objectives which both independently and interdependently contribute to the overall programme.

These objectives have been developed from those used elsewhere and recognise the need for outcomes that relate to the four dimensions shown below and taken from the blue print:

- To prevent people developing long-term conditions, diagnosing early and intervening sooner in order to minimise the adverse health consequences of long-term conditions (LTCs) and improve quality and life expectancy for citizens.

- To empower people with LTCs including the frail elderly to feel supported to manage their own health and care needs and live independently in their own homes for longer and less reliance on intensive care packages.

- Engage and enable primary care clinicians, health and social care professionals to deliver the right care at the right time in a joined up approach, improving the citizen experience of health and social care.

- Develop an integrated and financially sustainable health and social care system.

B3.7.3 Initial metrics

To establish an overarching evaluation methodology for the programme there needs to be a view about some of the metrics that would be appropriate and ensure that the programme aims have been met both during and at the completion of the programme.

The link between this domain and the IM&T domain are crucial for the evaluation work to ensure that the systems and datasets we have currently can either deliver the required information or are developed for this purpose as baselines must be set and variances be readily identified.

For this purpose, experience elsewhere and more locally from work undertaken in each of the 3 CCG areas, can be built upon.

Each of these areas will need further development to ensure that data and metrics, can be obtained as part of the evaluation process for each 'level' of the 'care model' as described in part A3.2. There will need to be an appropriate degree of sophistication about each of the measures for the care model levels so that the patient, user and carer outcomes are appropriate to the risk/characteristic described and the outcome gained.

The aggregation of this data, from an agreed baseline will demonstrate improvement, and service transformation over time.

Qualitative, quantitative and cost data will be required to make a full assessment of the success of the programme. A model for this has been set out in the "National Evaluation of the Department of Health's Integrated Care Pilots, March 2012 (Rand Europe and Ernst & Young)"

It must also be recognised that additional resources will be required to co-ordinate, manage and support this work as there will be extensive, inter-related data to analyse. This will also complement the work of the IM&T domain and provide support at the interface between organisations. The programme governance arrangements will need to support the evaluation domain as it too will operate at a programme level ensuring the necessary outcomes and benefits are delivered.

These data types will need to be mapped onto the main area for evaluation identified by the working group:

<u>Quality of care and health outcomes</u>

- Public health measures
- Access and service responsiveness
- GP registers completion
- Existing objective quality measures

Patient/user and carer experience

- Satisfaction surveys
- Patient diaries
- 'I' statements (measuring patient experience of integration in the NHS)

Professionals' experience

- Staff diaries
- Staff surveys
- Workforce development/engagement

Impact on service use and costs

Hospital utilisation (including mental health)

- Acute hospital admission rates
- Readmission rates
- Occupied bed days
- Delayed transfers of care
- A&E attendance

Community and primary care (including mental health)

- Community contacts
- GP attendance
- Cost of prescribing
- Nursing and residential home usage
- Social care contacts.

B3.7.4 Summary

The evaluation of the *Living longer, living better* programme is essential and must start from a clear set of objectives to ensure the programme aims are met.

Evaluation criteria will be required for each of the domains to ensure they contribute to the overall programme and demonstrate effectiveness and efficiency improvement.

Support from Manchester Academic Health Science partners is essential in the process to ensure that the evaluation criteria are valid, reflect the needs of the programme and provide clear measures which can be used to set milestones throughout the programme as well as at its conclusion.

B4 Recommendations

It is recommended that the Health and Wellbeing Board

- **Note the contents of this document**
- **Commit to supporting further work in all the domains included in part B, as set out in the individual chapters**
- **To receive a further, detailed, report on progress in September 2013.**

Appendix B1 - Organisations involved in the *Living longer, living better* programme

The following organisations make up the *Living longer, living better* programme and have worked together to produce this strategic outline case

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

Appendix B2 – Governance arrangements

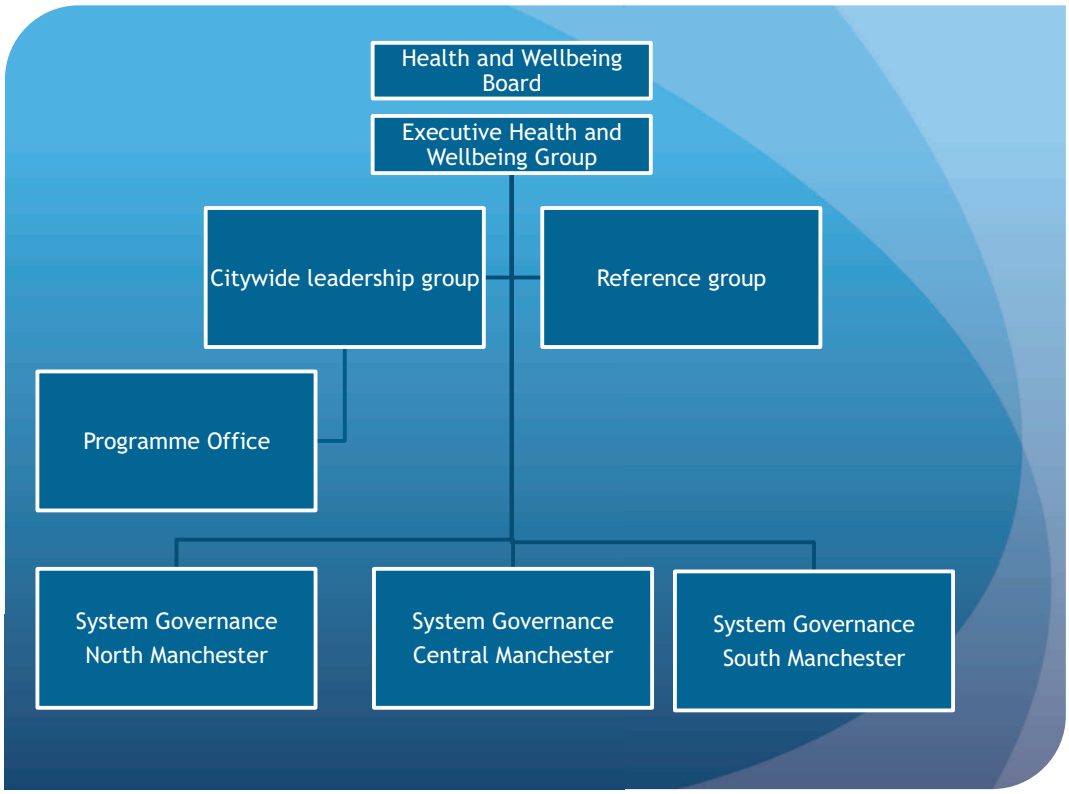
The *Living longer, living better* programme is accountable to the statutory Manchester Health and Wellbeing Board, through the Executive Health and Wellbeing Group which consists of all of the chief officers and chief executives of the organisations in the programme partnership.

Reporting to the Executive Health and Wellbeing Group, and responsible for the production of this strategic outline case, is the Citywide Leadership Group. The Citywide Leadership Group is advised by the programme's Professional Reference Group, which also reports to the Executive Health and Wellbeing Group. The programme senior responsible owner is Liz Bruce, Strategic Director of Families, Health and Wellbeing, Manchester City Council.

Beneath the city-wide arrangements each locality has its own governance and programme management system, with oversight from all local organisations involved. Local arrangements in each case include clinical commissioning group-specific Patient and Public Advisory Groups which will inform local integrated care plans from the perspective of patients, and advise on delivery

of the communication and public engagement necessary to support the programme.

The governance arrangements are illustrated in the figure below:



Appendix B3 – Contributors and acknowledgements

Many individuals have contributed to the contents of this strategic outline case. The following list details the people responsible for leading the development of specific domains of the programme and writing the relevant chapters of the strategic outline case.

- *Our people:* Helen Speed, North Manchester North Manchester Clinical Commissioning Group (NMCCG)
- *Our care model:* Sara Radcliffe, Central Manchester University Hospitals NHS Foundation Trust (CMFT)
- *Our contracting and funding:* Ed Dyson, Central Manchester Clinical Commissioning Group (CMCCG)
- *Our workforce:* Deborah Lyon, Pennine Acute Hospitals NHS Trust (PAHT)
- *Our buildings:* Joanne Royle, University Hospital of South Manchester NHS Foundation Trust (UHSM)
- *Our information:* Emma Gilbey, Manchester City Council (MCC)
- *Our system*: Claudette Elliott, South Manchester Clinical Commissioning Group (SMCCG)
- *Public engagement for better health*: Nick Gomm, Manchester Clinical Commissioning Groups

- *Our leadership:* Liz Bruce, MCC
- *Evaluating our progress:* John Harrop, Manchester Mental Health and Social Care Trust (MHMSCT)

These representatives, together with the following, constitute the *Living longer, living better* Citywide Leadership Group:

- Andy Bowie, MCC
- Annabel Hammond, UHSM

The City-wide Leadership Group is supported by a **Professional Reference Group** of clinicians and practitioners. The membership of this group is as follows**:**

Dr Ivan Benett, CCMCCG
Dr Mike Cheshire, CMCCG
Lucy Degisi, NMCCG
Dr Rachel Gordon, PAHT
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Dr David Ratcliffe, North West Ambulance Service NHS Trust (NWAS)
Dr Jonathan Simpson, CMCCG
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Dr Mark Whitaker, SMCCG
Mike Wild, Manchester Alliance for Community Care
Dave Williams, Manchester Carers Forum

For the **our people** domain, the author would like to thank the data analysis team of Neil Bendel, Patrick Godfrey and Graham Hayler for their support for this domain's outputs

For the **our care model** domain, the following people attended workshops on the domain subject:

13th May am		**13th May pm**		**16th May am**		**16th May pm**	
Name	**Org.**	**Name**	**Org.**	**Name**	**Org**	**Name**	**Org.**
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Sara Radcliffe	CMFT	Sara Radcliffe	CMFT	Sara Radcliffe	CMFT	Sara Radcliffe	CMFT
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Helen Speed	NMCCG	Helen Speed	NMCCG	Helen Speed	NMCCG	Helen Speed	NMCCG
Elizabeth Bradbury	AQuA	Elizabeth Bradbury	AQuA	Joanna Williams	UHSM	Joanne Royle	UHSM

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Nicola Thompson	MCC	Sheila Dawber	MCC	John Vass-de-Zomba	UHSM	Debbie Walker	MCC
James Williams	MCC	Angela Beacon	MCC	Sandra Jackson	MCC	Paul Teale	MCC
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Jerry MacSweeney	CMFT	Caroline Hourigan		Karen Fishwick	CMFT	Adrian Crook	CMFT
Mark Edwards	CMFT	Kimberley Salmon Jamieson	CMFT	David Furnival	CMFT	Kathy Hern	CMFT
Arwel Williams	CMFT	Jessica Hardcastle	CMFT	Suzanne Curtis	CMFT	Hazel Branney	CMFT
Theresa Clegg	CMFT	Jan Barnes	CMFT	Katie Foster	PAHT	Nicky Boag	CMFT
Jonathan O'Brien	CMFT	Ashley Harling	CMFT	Linda Kerwin	PAHT	Dr Prasanna Rao Balakrishna	CMFT
Lindsey Darley	PAHT	Mary Jones	CMFT	Deborah Lyon	PAHT	Caroline Lowthian	CMFT
Sharon Lord	PAHT	Sue Mason	PAHT	John Bevans	PAHT	Julie Harrison	CMFT
Wendy Jordan-Taylor	PAHT	Catherine Thomson	PAHT	Martin Jones	Central CCG	Helen Geach	CMFT
Karen Hughes	PAHT	Rachel Gordon	PAHT	Ed Dyson	Central CCG	Tina Davies	CMFT
	PAHT	Claudette Elliott	South CCG	Leigh Latham	Central CCG	Jo Daniels	PAHT
Nancy Ryalls	South CCG	John Harrop	MMHSCT	Ben Squires	Central CCG	Christine Stackhouse	PAHT
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						James Price	PAHT
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						Tony Ullman	Central CCG
						Helen Hosker	Central CCG
						Maeve Boyle	MMHSCT
						Ray Baird	MMHSCT
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The following people attended a workshop on the **our contracting and funding** domain and acted as a reference group:

Robert Breedon	Wragge and Co
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Carol Culley	MCC
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The domain author would like to thank Jack Sharp, Salford Royal NHS Foundation Trust, AQuA and the Kings Fund.

For the **our workforce** domain, the following people contributed to the chapter:

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For the **our buildings** domain, the following people supported worked on the chapter

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Jayne Cooney	SMCCG
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For the public engagement for better health and wellbeing domain, the following people contributed to the domain:

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David Regan	MCC
Vicky Bottomley	MCC
Andy Bowie	MCC
Yvonne Davies	CMFT
Joe Paxton	UHSM
Annabel Hammond	UHSM
Andrew Lynne	PAHT
Gabrielle Teague	PAHT
Clare Norman	Greater Manchester Commissioning Support Unit
Alison Whelan	Greater Manchester Commissioning Support Unit

For the **evaluating our progress** domain, the following people attended a workshop on the domain subject:

Name	**Organisation**
John Harrop	MMHSCT
Sarah Henry	MCC
Helen Speed	NMCCG
Nancy Ryalls	SMCCG
Helen Rooney	UHSM
Emily Hopkins	MMHSCT
Leigh Latham	CMCCG

Appendix B4 – Links to the Greater Manchester public sector reform programme

The Manchester integrated care programme is a component of a city-wide public service reform programme, which in turn is part of the Greater Manchester approach to public service reform. The main drivers for public

service reform are the requirement make a sustained reduction in demand and dependency, and moving people towards self-reliance and being able to contribute economically. It is expected that this will in turn boost Greater Manchester productivity that will impact on the national economic recovery.

The Greater Manchester public service reform programme lasts for five years. It has a focus on complex and intractable issues where one partner invests but others benefit, and reforms take time to generate a return on investment. The programme uses an investment approach that involves moving money between public services and across organisational boundaries in order to realise a return, and a focus on generating robust evaluation evidence that will give investors confidence.

Manchester's integrated care programme relates directly to the Greater Manchester public service reform programme, e.g., in its focus on:

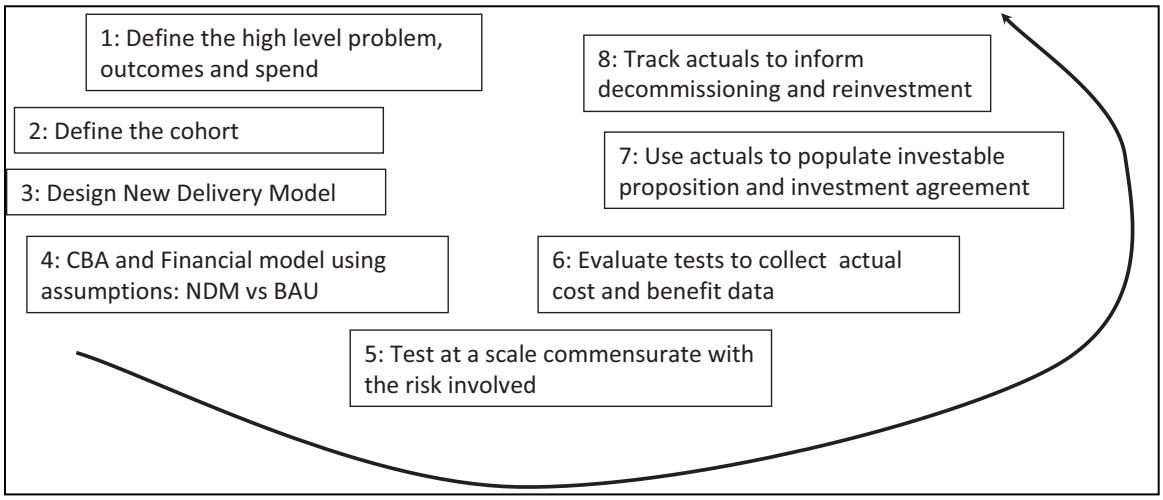
- Reducing hospital admissions (reducing dependency and demand)
- Emphasising prevention and avoidance of ill-health (moving people towards self-reliance and being able to contribute economically)
- Changed contractual arrangements between organisations (supporting a new approach to investment)

The table below shows the connection between the underpinning principles of Greater Manchester's public service reform programme, its methodology, and the *Living longer, living better* programme.

Underpinning principles	**Methodology**	**Links to *Living longer, living better***
• That a family-based approach will be more effective than focus on the individual, because families are a greater influence on individuals' behaviour than public services, and the whole family perspective provides a broader view of dependencies to better understand complex problems • That integrated, sequenced and co-ordinated interventions around families and	• Designing new delivery models that re-wire services around families and follow these three principles • New investment models for moving resources and money across organisational boundaries, which overcome the traditional barriers of one partner investing but others benefitting, and the time lags associated with investing in reform	• Starting with the definition of integrated care, the Living longer, living better programme acknowledges the vital importance of families and carers to successful integrated care arrangements • The programme is developing through this strategic outline case new contracting and investment models • The programme is developing a robust evaluation process (see B3.7) • Hospital inpatient

individuals will be more effective at reducing dependency and more cost-beneficial than poorly co-ordinated, unstructured interventions from a myriad of different agencies and professionals • Evidence-based interventions should be used where possible as these have a greater chance of success than non-evidence based interventions. Innovative interventions should be tested to generate evidence.	• A commitment to using robust evaluation evidence to inform investment decisions – for example by running proof of concept pilots for relatively small cohorts as the basis for negotiating investment, replacing modelled assumptions • Applying this methodology enables provision no longer required to be decommissioned safely. Integrated recommissioning to scale up what works, and early intervention and prevention.	services will no longer be required at the same scale as at present, and may be decommissioned. • The programme will continue to learn from evidence of effectiveness of integrated care locally, nationally and internationally (see appendix A1)

The schematic below illustrates the high-level process which Greater Manchester public service reform is applying in its priority areas. It will readily be seen that this strategic outline case addresses stages 2 and 3 of the Greater Manchester process.



Further detail about the Greater Manchester public service reform may be found in the *Background paper* of the Greater Manchester Technical Advisory Group, published on 29 April 2013 from which this appendix borrows with thanks.

Appendix B5 – Links to the *Healthier Together* programme

The Greater Manchester health reform programme, *Healthier Together*, has made clear the importance of integrated care at local level to the future configuration of acute hospital services across Greater Manchester. In March 2013, the board of NHS Greater Manchester approved the strategic direction case for *Healthier Together*, which included a set of ten common components for integrated care at local level. The expectation of NHS Greater Manchester was that local NHS organisations and their local authority partners would ensure that, in their design of integrated care to meet local needs, the same set of common components would be found in each system. The table below contains the *Healthier Together* 'common components' and summarises their relationship with *Living longer, living better*

'Common components'	**Description from *Healthier Together***	**Link to *Living better, living longer***
Accessible and responsive	Care services will be easily accessible and responsive. Primary care and GPs should act as the 'first port of call' particularly for people with long term conditions	Accessibility is critical to the service model (see A3.2)
Providers working together	Health and social care teams will work in an integrated way particularly for the frail elderly and people living with long-term conditions. Patients and their carers will experience care provided in a seamless way with unnecessary duplication avoided as a result of effective collaboration between those involved in the planning and delivery of care	Integrated health and social care teams are central to the service model of *Living longer, living bette*r (see A3.2) The experience of seamless care by patients and carers is a fundamental goal of the programme (see section A2)
Support for self-care and independence	Patients, individuals and their carers will be supported and empowered to take ownership of their care and wellbeing so that they are able to live independently and so that health and social care resources are targeted on the most vulnerable	This is a fundamental principles behind *Living longer, living better* (see section A3.2)

Quick response to urgent needs	There will be rapid access and response to urgent care needs to minimise the reliance on Accident and Emergency and to ensure that the most appropriate care is provided	This is a basic component of the service model (see A3.2)
Planned pathways of care	Agreed care pathways and protocols will be in place to ensure that the patients receive standardised care with reduced variability and unnecessary attendances	This is a basic component of the service model (see A3.2)
Appropriate hospital and specialist care only when required	Patients will receive appropriate specialist input in a timely manner when required and will only spend the appropriate time in hospital with planned discharge in the community as early as possible	This is a key goal of the programme (see A2 and A3.2)

Appendix B6 – Estates summary

Key:	Blue = Central	Yellow = North	Green = South					
PRIMARY MEDICAL CARE ESTATE								
ID	**Column 1: Property Name & Address**	**Address**	**Column 2: Postcode**	**Column 3: Area (m2)**	**Column 4: Owned / Leased**	**Column 5: Tenants/Occupiers. Please list**	**Column 6: Lease/Licence/SLA**	**Column 7: Managed by e.g. LIFT**
P84005	Dr Ngan & Chan	Brunswick Centre GP Practice, Hartfield Close, Manchester	M13 9YX	NHS Health Centre	Actual Rent			LIFT
P84009	Alisa Craig Medical Group	270 Dickenson Road, Manchester	M13 0YL	202.5	Cost Rent/Notional Rent			
P84016	Levenshulme Health Centre	Dunstable Street, Levenshulme	M19 3BX	NHS Health Centre	Actual Rent			PCT
P84023	Surrey Lodge Group Practice	11 Anson Road, Victoria Park, Manchester	M14 5BY	520.86	Notional Rent			Owner Occupied
P84026	Shiv Lodge Medical Centre	357-359 Dickenson Road, Longsight, Manchester	M13 0WQ	310.07	Cost Rent/Notional Rent			Owner Occupied
P84027	West Point Medical Centre	167-169 Slade Lane, Levenshulme, Manchester	M19 2AF	367.53	Notional Rent			Owner Occupied
P84028	Gorton Medical Centre	46 Wellington Street, Gorton, Manchester	M18 8LJ	181.5	Notional Rent			Owner Occupied
P84037	Dr Cunningham	Brunswick Centre GP Practice, Hartfield Close, Manchester	M13 9YX	NHS Health Centre	Actual Rent			LIFT

P84038	Ashville Surgery	171 Upper Chorlton Road, Whalley Range, Manchester	M16 9RT	390.4	Notional Rent				Owner Occupied
P84039	The Range Medical Centre	121 Withington Road, Whalley Range, Manchester M16 8EE	M16 8EE	549.2	Actual Rent				OTHER
P84050	Mount Road Surgery	110 Mount Road, Gorton, Manchester	M18 7BQ	200.1	Cost Rent/Notional Rent				Owner Occupied
P84052	West Gorton Medical Centre	6a Wenlock Way, West Gorton, Manchester	M12 5JN	313.52	Cost Rent/Notional Rent				Owner Occupied
P84053	Ashcroft Surgery	803 Stockport Road, Levenshulme, Manchester	M19 3BS	433.3	Cost Rent/Notional Rent				Owner Occupied
P84056	Princess Road Surgery	471-475 Princess Road, Withington, Manchester	M20 1BH	234.4	Notional Rent				Owner Occupied
P84057	The Kaya Practice	1 Nicolas Road, Chorlton, Manchester	M21 9NJ	NHS Health Centre	Actual Rent				PCT
P84063	Dr Chen & Davis	1 Nicolas Road, Chorlton, Manchester	M21 9NJ	NHS Health Centre	Actual Rent				PCT
P84068	Dr Ratcliffe & Chew-Graham	1 Nicolas Road, Chorlton, Manchester	M21 9NJ	NHS Health Centre	Actual Rent				PCT
P84071	The Wilbraham Surgery	515 Wilbraham Road Chorlton, Manchester	M21 0UF	135.7	Notional Rent				OWNER OCCUPIED
P84072	The Robert Darbishire Practice	Walmer Street, Rusholme, Manchester,	M14 5NP	NHS Health Centre	Actual Rent				PCT

P84611	Dr Chiu	Brunswick Centre GP Practice, Hartfield Close, Manchester	M13 9YX	NHS Health Centre	Actual Rent				LIFT
P84616	Dr Drah	Monton Street, Moss Side, Manchester	M14 4GP	NHS Health Centre	Actual Rent				PCT
P84626	Wilmslow Road Medical Centre	156A Wilmslow Road, Rusholme, Manchester	M14 5LQ	122.11	Notional Rent				Owner Occupied
P84627	The Surgery	63 Reddish Lane, Gorton, Manchester	M18 7JH	98.1	Notional Rent				Owner Occupied
P84630	The Arch Medical Centre	The Arch Medical Practice, 175 Royce Road, Hulme	M15 5EA	310.57	Notional Rent				Owner Occupied
P84635	The Alexandra Range Medical Centre	2 Whitswood Close, Alexandra Park, Manchester	M16 7AP	NHS Health Centre	Actual Rent				PCT
P84644	Parkside Surgery	187 Northmoor Road, Manchester	M12 5RU	113.5	Notional Rent				Owner Occupied
P84650	The Alexandra Practice	365 Wilbraham Road, Whalley Range, Manchester	M16 8NG	193.3	Cost Rent/Notional Rent				Owner Occupied
P84652	Dr Jaiswal's Practice	9 Corkland Road, Chorlton cum Hardy, Manchester	M21 2UR	197.03	Notional Rent				Owner Occupied
P84659	Dr Hussain	Monton Street, Moss Side, Manchester	M14 4GP	NHS Health Centre	Actual Rent				PCT
P84669	Cornbrook Surgery (Boundary Lane)	63 Booth Street West, Manchester,	M15 6EP	199.66	Actual Rent				OTHER

		M15 6PR							
P84669	Cornbrook Surgery (City Road)	204 City Road, Hulme, Manchester	M15 4EA	147.35	Cost Rent/Notional Rent				Owner Occupied
P84676	Oswald Medical Practice	4 Oswald Road, Chorlton, Manchester	M21 9LH	235.66	Cost Rent				Owner Occupied
P84683	The Docs	55-59 Bloom Street, Manchester	M1 3LY	369.4	Notional Rent				Owner Occupied
P84683	The Doc's	55-59 Bloom Street, Manchester, M1 3LY	M9 2LA	369.4	Actual Rent				OTHER
P84689	Longsight Medical Practice	526/528 Stockport Road, Longsight, Manchester	M13 0RR	NHS Health Centre	Actual Rent				PCT
Y02890	Hawthorn Medical Centre	Unt K, Fallowfield Retail Park, Birchfields Road, Levenshulme, Manchester, M14 6FS	M14 6FS	NHS Health Centre	Actual Rent				?? (PCT)
Y02960	New Bank Health Centre	339 Stockport Road, Longsight, Manchester, M12 4JE	M12 4JE	NHS Health Centre	Actual Rent				?? (PCT)
P84004	Five Oaks Family Practice	47 Graham Street, Beswick, Manchester	M11 3BB	563.33	Notional Rent				Owner Occupied
P84019	Valentine Medical Centre	2 Smethurst Street, Blackley, Manchester, M9 8PP	M9 8AJ	558.27	Actual Rent				OTHER

P84025	St Georges Medical Centre	St Georges Drive, Moston, Manchester	M40 5HP	216.9	Notional Rent				Owner Occupied
P84030	New Collegiate Medical Centre,	407 Cheetham Hill Road, Cheetham, Manchester, M8 0DA	M8 0DA	696.71	Actual Rent				OTHER
P84032	Dr Mokashi	89 North Road, Manchester,	M11 4FJ	NHS Health Centre	Actual Rent				PCT
P84033	Higher Blackley Medical Centre	156 Victoria Avenue, Blackley, Manchester	M9 3RN	272.1	Notional Rent				Owner Occupied
P84040	Conran Medical Centre	77 Church Lane, Harpurhey, Manchester	M9 5BH	409.8	Notional Rent				Owner Occupied
P84041	Cornerstone Family Practice	Graham St, Manchester	M11 3AA	148	Actual Rent				PCT
P84042	Florence House MP	Ashton Old Road, Higher Openshaw, Manchester	M11 1JG	NHS Health Centre	Actual Rent				LIFT
P84046	Dr Bokhari	244 Cheetham Hill Road, Manchester	M8 8UP	NHS Health Centre	Actual Rent				LIFT
P84046	Dr Bokhari	The Surgery, 58 Rochdale Road, Collyhurst, Manchester, M40 7GT	M40 7GT	??	Actual Rent				OTHER
P84047	Droylsden Family Practice	125 Droylsden Road, Newton Heath, Manchester	M40 1NT	178.9	Notional Rent				Owner Occupied
P84049	The Avenue Medical Centre	51/53 Victoria Avenue, Blackley, Manchester	M9 6RA	178.4	Notional Rent				Owner Occupied

P84051	Dr Goodall & Glass	89 North Road, Manchester,	M11 4FJ	NHS Health Centre	Actual Rent			PCT
P84054	Whitley Road Medical Centre	1 Whitley Road, Collyhurst, Manchester, M40 7QH	M40 7QH	245.19	Actual Rent			OTHER
P84059	The Family Surgery	863 Ashton New Road, Clayton, Manchester	M11 4PB	154.1	Notional Rent			Owner Occupied
P84062	Brookdale Surgery	202 Droylsden Road, Newton Heath, Manchester	M40 6NZ	144.1	Notional Rent			Owner Occupied
P80464	New Islington Medical Centre	Ancoats Primary Care Centre, Old Mill Street, Ancoats, Manchester, M4 6EE	M4 6EE	NHS Health Centre	Actual Rent			LIFT
P84065	Harpurhey Health Centre	1 Church Lane, Harpurhey, Manchester, M9 4BE	M9 4BE	NHS Health Centre	Actual Rent			PCT
P84067	The Hazeldene Medical Centre	97 Moston Lane East, New Moston, New Moston, Manchester	M40 3HD	314.1	Cost Rent			Owner Occupied
P84070	Newton Heath Health Centre	2a Old Church Street, Newton Heath, Manchester, M40 2JF	M40 2JF	NHS Health Centre	Actual Rent			PCT
P84074	Wellfield Medical	53 - 55 Cresent Rd, Crumpsall, Manchester, M8 7ST	M8 7TJ	433.3	Actual Rent			OTHER
P84605	The Fernclough Surgery	Unit 1, Travistock	M9 1SZ	89.6	Notional Rent			Owner Occupied

P84623	Aleeshan Medical Centre	3 Shirley Road, Cheetham Hill, Manchester	M8 0WB	108.8	Notional Rent					Owner Occupied
P84631	Artane Medical Centre	1 Middleton Road, Higher Crumpsall, Manchester	M8 5DS	113.4	Notional Rent					Owner Occupied
P84637	Dr Mazari	89 North Road, Manchester,	M11 4FJ	NHS Health Centre	Actual Rent					PCT
P84640	Queens Medical Centre	244 Cheetham Hill Road, Manchester	M8 8DE	NHS Health Centre	Actual Rent					LIFT
P84645	Park View Medical Centre	66 Delauneys Road, Crumpsall, Manchester	M8 4RF	193.87	Notional Rent					Owner Occupied
P84663	The Village Surgery	25 Old Market Street, Blackley, Manchester	M98DT	186.12	Notional Rent					Owner Occupied
P84673	Urban Village Medical Practice	Ancoats Primary Care Centre, Old Mill Street, Ancoats, Manchester, M4 6EE	M4 6EE	NHS Health Centre	Actual Rent					LIFT
P84679	1 Willowbank Surgery	Church Lane, Harpurhey, Manchester	M9 4WH	102.8	Notional Rent					Owner Occupied
P84684	The Jolly Medical Centre	72/74 Cresent Road, Crumpsall, Manchester	M8 9NT	189.79	Notional Rent					Owner Occupied
P84690	Dam Head Medical Centre	1020 Rochdale Road, Blackley, Manchester, M9 7HD	M9 2LA	107.3	Actual Rent					OTHER

Y01695	Victoria Mill Health Care Centre	10 Lower Vickers St, Manchester	M40 7LH	NHS Health Centre	Actual Rent			PCT
Y02325	Charlestown Medical Practice	Charlestown Road, Charlestown, Manchester, M9 7ED	M9 7ED	NHS Health Centre	Actual Rent			PCT
Y02520	Simpson Medical Practice	36 Moston Lane, Moston, Manchester, M40 9NB	M40 9NB	??	Actual Rent			OTHER
Y02849	City Health Centre	Second Floor, 32 Market Street, Manchester, M1 1PL	M1 1PL	??	Actual Rent			OTHER
P84010	The Borchardt Medical Centre	62 Whitchurch Road, Withington, Manchester,	M20 1EB	557.62	Actual Rent			OTHER
P84012	Northenden Group Practice	489 Palatine Road, Northenden, Manchester	M22 4DH	NHS Health Centre	Actual Rent			PCT
P84014	R K Medical Practice	171 Brownley Road, Benchill, Wythenshawe, Manchester	M22 9UH	NHS Health Centre	Actual Rent			LIFT
P84017	Ladybarn Group Practice	54 Briarfield Road, Withington, Manchester, M20 4SS, Manchester	M20 4SS	1040	Actual Rent			OTHER
P84018	Mauldeth Medical Centre	112 Mauldeth Road, Fallowfield, Manchester	M14 6SQ	146.4	Notional Rent			Owner Occupied
P84020	Peel Hall MP	Simonsway, Wythenshawe,	M22 5RX	NHS Health	Actual Rent			LIFT

		Manchester		Centre					
P84021	Maples Medical Centre	2 Scout Drive, Newall Green	M23 2SY	236.66	Cost Rent /Notional Rent				Owner Occupied
P84022	Kingsway Medical Practice	720 Burnage Lane. Burnage	M19 1UG	268.9					Third Party Developer
P84024	Bowland Medical Practice	52 Bowland Road, Baguley, Manchester	M23 1JX	399.96	Notional Rent				Owner Occupied
P84029	Benchill Medical Practice	171 Brownley Road, Benchill, Wythenshawe, Manchester	M22 9UH	NHS Health Centre	Actual Rent				LIFT
P84034	Barlow Medical Centre	828 Wilmslow Road, Didsbury, Manchester , M20 2RN	M20 2RN	919.12	Actual Rent				OTHER
P84035	Bodey Medical Centre	Ladybarn Court, 28 Ladybarn Lane, Fallowfield. M14 6WP	M14 6WP	718.4	Actual Rent				OTHER
P84043	Cornishway Medical Group Practice	The Forum Health, Simonsway, Wythenshawe, Manchester	M22 5RX	NHS Health Centre	Actual Rent				LIFT
P84045	The Park Medical Centre	434 Altrincham Road, Baguley, Manchester	M23 9AB	193.1	Cost Rent				Owner Occupied
P84048	Tregenna Group Practice	Portway, Manchester	M22 OEP	290.6	Notional Rent				Owner Occupied
P84055	Merseybank Surgery	36 Merseybank Ave, Chorlton	M21 7NN	132	Actual Rent				OTHER
P84061	Brooklands Medical Practice	594 Altrincham Road, Brooklands, Manchester,	M23 9JH	136.8	Notional Rent				Owner Occupied

P84066	David Medical Centre	274 Barlow Moor Road, Chorlton-cum-Hardy, Manchester	M21 8HA	233.95	Notional Rent					Owner Occupied
P84639	Fallowfield Medical Centre	75 Ladybarn Lane, Fallowfield, Manchester	M14 6YL	135.6	Notional Rent					Owner Occupied
P84651	Northern Moor Medical Practice	216a Wythenshawe Road, Manchester	M23 0PH	60.04	Notional Rent					Owner Occupied
P84665	Al-Shiefa Medical Centre	6 Copson Street, Withington, Manchester	M20 3HE	177.69	Notional Rent					Owner Occupied
P84672	Woodlands Medical Practice	9 Maple Road, Brooklands, Manchester	M23 9RL	99.9	Notional Rent					Owner Occupied
P84677	Didsbury Medical Centre (Dr Ashworth)	645 Wilmslow Road, Didsbury, Manchester	M20 6BA	178.6	Notional Rent					Owner Occupied
P84678	Didsbury Medical Centre (Dr Whittaker)	645 Wilmslow Road, Didsbury, Manchester	M20 6BA	178.6	Notional Rent					Owner Occupied
MCC										
ID	**Column 1: Property Name & Address**	**Address**	**Column 2: Postcode**	**Column 3: Area (m2)**	**Column 4: Owned / Leased**	**Column 5: Tenants/Occupiers. Please list**	**Column 6: Lease/Licence/SLA**			**Column 7: Managed by e.g. LIFT**
77176676	Chapman Place Day/Resource Centre (closed 2013)		M18 8UA	1118	Owned	Vacant	N/A			MCC
10023061272	Claremont Community Resource Centre		M15 5FS	1266	Owned	MCC, MMHSCT, Mothers Against Violence, Fountain of Life, Afro-Caribbean Care Group	SLA			MCC

10090665670	Debdale Park Day Centre		M18 7LJ	154	Owned	MLDP	SLA	MCC
10023049758	Gorton South Neighbourhood Office		M18 7BE	1591	Owned	MCC & NHS Primary Assessment Team	Informal	MCC
10090241089	Hulme Centre (community facility)		M15 5ES	320	Owned	Various sessional uses by community groups	Informal	MCC
10023049592	Mellands Centre - Day Centre		M18 7QA	246	Owned	Operated by Age Concern, Manchester	SLA	MCC
77236386	Moss Side District Office		M16 7AD	1058	Owned	MCC-Adults & Chilrends; MLDP	SLA	MCC
77089443	Cornbrook Enterprise Centre - Day Centre		M15 4HW	500	Owned	MCC	N/A	MCC
	Longsight District Office		M12 4LL	897	Owned	MCC Adults & Childrens	N/A	MCC
	Wenlock Way Offices		M12 5DH	6670	Leased	MCC Adults & Childrens Services & others incl Out of Hours contact team	N/A	MCC
	Chorlton District Office	102 Manchester Road	M21 9SZ	1367	Leased	MCC Childrens, Neighbourhoods & Police	Lease	MCC & private landlord - break available in 2017
	Westwood Street Offices		M14 4SW	713	Owned	MCC Childrens	N/A	MCC
	Ardwick SureStart	Medlock Schoold, Wadeson Road	M13 9UJ	480	Owned	Children's Centre	SLA	Medlock School Governors
	Chorlton Park SureStart	Barlow Hall Primary School, Darley Avenue	M21 7JG	212	Owned	Children's Centre	N/A	MCC
	Fallowfield SureStart	Wilbraham Primary School	M14 7FB	184	Owned	Children's Centre	N/A	MCC
	Gorton North SureStart	James' School, Stelling Street	M18 8LW	70	Owned	Children's Centre	N/A	MCC
	Gorton South SureStart	Mount Road	M18 7BG	576	Owned	Children's Centre	N/A	MCC

	Martenscroft SureStart	Martenscroft Nursery School, Epping Street	M15 6PA	TBC	Owned	Children's Centre	N/A	School Governors
	Whalley Range SureStart	St Margaret's CofE Primary	M16 8HE	224	Owned	Children's Centre	N/A	MCC
77180470	Clayton Centre	Barrington Street Luncheon Club	M11 4FB	287	Owned	MCC	N/A	MCC
10012725663	Harpurhey Day Centre		M9 5BG	583	Owned	MMHSCT	575	MCC
77015035	Harpurhey District Office		M9 4DP	1549	Owned	MCC Offices & public reception - Adults, Childrens, Neigbourhoods, Regen, MMHSCT, Credit Union	SLA	MCC
10090666559	Heathfield Hall (Day Centre)		M40 1LF	207	Owned	MCC & MLDP	SLA	MCC
10023051342	Heathfield Resource Centre		M40 1LF	1200	Owned	MCC & MLDP	SLA	MCC
10090666480	Northfield Community Resource Centre		M40 0RL	1258	Owned	MCC & MLDP	SLA	MCC
77186830	Openshawe Resource Centre (closing May 2013)		M11 1WF	814	Owned	MCC	N/A	MCC
10023049714	Unit 3 Tulketh Street Industrial Estate (equipment store)		M40 9LY	420	Owned	MEAP	Lease	MCC
77037759	354-356 Lightbrowe Road (offices)		M40 0HJ	500	Owned	MCC	N/A	MCC
77139701	Part Second Floor, Victoria Mill (Offices) - Lease due to end Jan 2014		M40 7LJ	260	Leased	MCC	Lease	Private Landlord
10090666648	Part fourth floor, Victoria Mill (Offices) - Lease due to end Jan 2014		M40 7LJ	1350	Leased	MCC & MEAP	Lease	Private Landlord
10090666647	Part basement, Victoria Mill (equipment store) - lease due to end Jan 2014		M40 7LJ	105	Leased	MCC & MEAP	Lease	Private Landlord

	Abraham Moss Learning & Disability Bungalow		M8 5UF	C.80	Owned	MLDP	SLA	MCC
	Stirling Centre - Day Centre		M40 6RA	241	Owned	Community Centre		
	Eric Hobin Centre - Day Centre		M9 7HR	374	Leased	MCC	SLA	SLA
	Ashbury Meadow Surestart	Ashbury Meadon Primary School, Rylance Street	M11 3NA	430	Owned	Children's Centre	N/A	MCC
	Broadhurst Park SureStart		M40 0FJ	222	Owned	Children's Centre	N/A	MCC
	Cheetham Fulmead Surestart		M8 9DW	734	Owned	Children's Centre	N/A	MCC
	Collyhurst SureStart	Collyburst Nursery School, Teignmouth Avenue	M40 7QD	190	Owned	Children's Centre	N/A	Nursery School Governors
	Harpurhey SureStart	North City Family & Fitness	M9 4DA	TBC	Leased	Children's Centre	N/A	MCC & Sports & Leisure Trust
	Miles Platting & Ancoats SureStart	Park View Community Primary, Holland Street	M40 7DA	TBC	Owned	Children's Centre	N/A	Family Action
	St Clement's SureStart	St Clements CofE Primary, Melville Close	M11 1LR	156	Owned	Children's Centre	N/A	MCC
	Woodville SureStart	Shirley Road	M8 0NE	1248	Owned	Children's Centre	N/A	MCC & Acorn Grove
77082829	Buckthorne House Resource Centre		M21 7UG	154	Owned	MCC	N/A	MCC
10090665755	Crossacres Community Resource Centre		M22 5AD	1235	Owned	Age Concern Manchester	S75	MCC
77239711	Hall Lane Resource Centre		M23 1WD	2130	Owned	MCC & MMHSCT	S75	MCC
10023050187	Kingslea House Offices	Southdown Business Centre	M20 9XP	296	Owned	MMHSCT	S75	MCC
77092329	Minehead Centre - Resource Centre		M20 1FW	1400	Owned	MCC & MMHSCT	S75	MCC

10090666481	Oakwood Resource Centre		M22 4HY	1805	Owned	MCC & MLDP	SLA	MCC
10070401254	Unit 1 Christie Park Offices		M21 7QY	500	Leased	MCC, MHS Primary Assessment Team	N/A	Private Landlord
	Etrop Court Offices (Wythenshawe Area Office)		M22 5RG	4520	Leased	MCC Adults, Childrens, Regen, Connexions	Lease	MCC
	Benchill SureStart		M22 4PZ	869	Leased	Children's Centre	SLA	Barnardos
	Didsbury Park SureStart	Wilmslow Road	M20 2RW	224	Owned	Children's Centre	N/A	MCC
	Old Moat SureStart	Old Moat Lane	M20 1DE	916	Owned	Children's Centre	N/A	MCC
	Woodhouse Park SureStart	Ringway Primary School, Dinmore Road	M22 1NW	401	Owned	Children's Centre	N/A	Barnardos

COMMUNITY

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	Abbey Hey Clinic	Constable Street, Gorton	M18 8GD	447.56	LIFT Lease	Sessional Use, NHS Funded Care (CHC/FNC)	SLA	CHP / NHS PS
	Alexandra Park Health Centre	2 Whitswood Street, Manchester	M16 7AP	1112.71	Leasehold	Community Domiciliary Physiotherapy, Falls Service, Dr Chaudurys Practice, The Alexandra Range MP, Sessional Use	SLA (GPs have no leases)	NHS PS
	Brunswick Health Centre	Hartfield Close, Manchester	M13 9YA		Freehold			NHS PS
	Chorlton Health Centre	1, Nicolas Street, Chorlton	M21 9NJ	1107.36	Freehold	District Nursing (Evenings & Night Service/Rapid Response), Community Dental Services, Dr Ratcliffe & Chew-Graham, Drs Chen & Davis, The kaya Practice, Sessional Use	SLA, GP has no lease	NHS PS
	City Health Centre	Second Floor (Boots), 32 Market Street, City Centre,	M1 1PL	931.04	Lease	Equitable Access GP Practice	GP has direct lease	NHS PS

	Manchester						
Cornerstone Centre	Graham Street, Beswick	M11 3AA	1398.66	Freehold	Community Dental Services, Mill Street Practice, District Nursing, District Nursing including Evenings and Nights Service/Rapid Response, Sessional Use	SLA, GP has no lease	NHS PS
Enterprise House (Unit 21)	Manchester Science Park, Manchester	M15 4EN	61.33	Lease	Family Nurse Partnership	SLA	NHS PS
Enterprise House (Unit 25)	Manchester Science Park, Manchester	M15 4EN	39.54	Lease	Family Nurse Partnership	SLA	NHS PS
Gorton Clinic	Blackwin Street, Gorton	M12 5JY	416.11	Freehold		SLA	NHS PS
Levenshulme Health Centre	Dunstable Street, Levenshulme	M19 3BX	1229.91	Freehold	Community Domiciliary Physiotherapy, Levensulme Health Centre, Sessional Use	SLA	NHS PS
Longsight Health Centre	526/528 Stockport Road, Longsight	M13 ORR	1743.96	Leasehold	Tier 2 MSK Central, Community Children's Nursing Team, Longsight Medical Practice, Sessional Use	SLA, GP has no lease	NHS PS
Moss Side Health Centre	Monton Street, Moss Side	M14 4GP	1421.41	Leasehold	Active Case Management Service Central, District Nursing (Evenings & Night Service/Rapid Response), Audiology, RU Clear, Community Dental Services, Dr Hussain, Moss Side Family Medical Practice, Sessional Use	SLA, GP has no lease	NHS PS
New Bank Health Centre	339 Stockport Road, Longsight , Manchester	M12 4JE	539.5	Lease	Equitable Access GP Practice	GP has direct lease	NHS PS

	Parkway 1 (Part First & Second Floors)	Parkway Business Centre, Princess Road	M14 7HR	1189.24	Lease	CCG and GMCSU	SLA, leases awaiting agreement	NHS PS
	Parkway 3	Parkway Business Centre, Princess Road	M14 7HR	2695.74	Lease	Central & South Manchester CCG, NWAS	SLA, leases awaiting agreement	NHS PS
	Parkway 5 (Ground, First & Second Floor)	Parkway Business Centre, Princess Road	M14 7HR	489.58	Freehold	CMFT on ground and 1st floor	SLA	UHSMFT
	Rusholme Health Centre	Walmer Street, Rusholme	M14 5NP	2202.85	Leasehold	Podiatry, The Robert Darbishire Practice, Not Occupied, Sessional Use	SLA, GP has no lease	NHS PS
	Vallance Centre	Brunswick Street, Manchester	M13 9UJ	2445.01	LIFT Lease	Active Case Management Service Central, Continence Service - Central, District Nursing (Evenings & Night Service/Rapid Response), School Nurses, Community Dental Services, Dr Chiu, Dr Cunningham & Partners, Dr Ngan, Chan & Koh, Sessional Use	SLA, GPs have leases	CHP / NHS PS
	Windrush Millenium Centre (Unit 17 & 18)	70, Alexandra Road, Moss Side	M16 7WD	81.63	Leasehold		None in place	NHS PS
	Ancoats Primary Care Centre	Old Mill Street, Ancoats	M4 6EE	2077.77	Lease	New Islington MC - Dr Pattoo, Urban Village Medical Practice, Active Case Management Service North, Sessional Use	Lease, SLA	NHS PS
	Charlestown Road Health Centre	Charlestown Road, Blackley	M9 7ED	1009.9	Leasehold	Care UK (Charlestown MP), Sessional Use, Smile 365	SLA, Care UK and Smile 365 both have leases in place	UHSMFT

Cheetham Hill Primary Care Centre	244, Cheetham Hill Road, Manchester	M8 8UP	1830.16	LIFT Lease	Health Visiting Service, School Nurses, Speech & Language Therapy, Contraceptive ASH, Dr Bokhari, Active Case Management Service North, District Nursing including Evenings and Nights Service/Rapid Response, Sessional Use		CHP / NHS PS
City Works (Unit 10, Norbury Court)	Welcomb Street, Manchester	M11 2NB	418.75	Lease		SLA	NHS PS
Clayton Health Centre	89, North Road, Clayton	M11 4EJ	1329.04	Leasehold	Dr Goodall & Glass, Dr Mazhari & Khan, Dr Mokashi & Partners, Sessional Use	SLA, GP has no lease	NHS PS
Crescent Bank	Humphrey Street, Crumpsall	M8 9JS	566.31	Freehold	LEARNING DISABILITY	SLA	NHS PS
Harpurhey Health Centre	1 Church Lane, Harpurhey, Manchester, M9 4BE	M9 4BE	1028.25	Leasehold	Health Visiting Service, School Nurses, Community Dental Services, The Harpurhey Health Centre, District Nursing, Sessional Use	SLA, GP has no lease	NHS PS
Higher Openshaw Primary Care Centre	Ashton Old Road, Openshaw	M11 1JG	1135.62	Lease	Florence House Medical Practice, Sessional Use	SLA, GP has Lease	NHS PS
Newton Heath Health Centre	Old Church Street, Newton Heath	M40 2JF	1067.76	Leasehold	Community Paediatrics, Health Visiting Service, Healthy Schools (PHDS), Orthoptics, Community Dental Service, Newton Heath Health Centre, Community Stroke Rehabilitation Team, Continence (North Locality), Sessional Use	SLA, GP has no lease	NHS PS

	Newton Silk Mill (Lower Ground, Ground, First & Second Floor)	Holyoak Street, Newton Heath	M40 1HA	817.28	Lease	Speech & Language Therapy, Primary Care Mental Health, Intermediate Care, NHS Funded Care (CHC/FNC) (North Locality), Community Occupational Therapy	SLA	NHS PS
	Plant Hill Clinic	Plant Hill Road, Blackley	M9 8LX	574.81	Freehold	Health Visiting Service, Community Dental Services, District Nursing, Not Occupied, Sessional Use	SLA	NHS PS
	Simpson Medical Practice	361 Moston Lane, Moston	M40 9NB	261.21	Lease	Equitable Access GP Practice	GP has direct lease	NHS PS
	Victoria Mill (Ground & 2nd Floor)	10 Lower Vickers Street, Miles Platting	M40 7JL	818.75	Lease	Community Nutrition Service (North Locality), District Nursing, Smoking Sessation, Macmillan Services (North Locality), GP Practice, Sessional Use	SLA, GP has no lease	NHS PS
	Waulk Mill (Unit 3.1)	51 Bengal Street, Ancoats	M4 6LN	276.75	Lease		None in place	NHS PS
	144 Wythenshawe Road	144, Wythenshawe Road, Northern Moor	M23 0PF	191.15	Freehold	LD Family Support Unit	SLA	NHS PS
	Baguley Clinic	206 Hall Lane, Baguley	M23 1NA	563.82	Freehold	Community Dental Services, MacMillan Services, NHS Funded Care (CHC/FNC)	SLA	NHS PS
	Brownley Green Primary Care Centre	Brownley Road, Wythenshawe	M22 4GA	2175.81	LIFT Lease	Audiology, Health Visiting Service, Speech & Language Therapy, Community Dental Services, Benchill Medical Practice, R K Medical Practice, Rapid Response, Sessional Use		CHP / NHS PS

	Burnage Health Centre	347 Burnage Lane, Burnage	M191EW	986.6	Freehold	Health Visiting Service, Burnage Healthcare Practice, Community Physiotherapy, Sessional Use	SLA, GP has no lease	NHS PS
	Didsbury Clinic	645 Wilmslow Rd, Didsbury	M20 6BA		Freehold		N/A	NHS PS
	Forum Health	Simonsway, Wythenshawe, Manchester	M22 5RX	2390.82	LIFT Lease	Orthoptics, Speech & Language Therapy, Community Dental Services, Contraceptive ASH, Cornishway Group Practice, Peel Hall Medical Practice, Coronary Heart Disease Service Development/Community Phass III Cardiac Rehabilitation Service, Podiatry, Not Occupied, Sessional Use	SLA, All GPs have leases	CHP / NHS PS
	Hawthorn Medical Centre	Unit K - Fallowfield Retail Park, Birchfields Road, Manchester	M14 6FS	473.68	Lease	Equitable Access GP Practice	GP has direct lease	NHS PS
	Monet Lodge	67 Cavendish Road, Withington, Manchester	M20 1JG	1039.21	Freehold	Care Home	Provider has direct lease	NHS PS
	Northenden Health Centre	489, Palatine Road, Northenden	M22 4DH	1123.69	Leasehold	Health Visiting Service, Northenden Group Practice, Sessional Use	SLA, GP has no lease	NHS PS
	Northern Moor Clinic	Moorcroft Road, Northern Moor	M23 0AF	290.16	Freehold	Dental Practice (lease expired)	SLA	NHS PS
	Rodney House	388, Slade Lane, Levenshulme	M19 2HT	958.54	PFI Lease		None in place	NHS PS
	Withington Clinic	535, Wilmslow Road,	M20 4BA	444.38	Leasehold	Community Dental Services, Sessional Use	SLA	NHS PS

		Withington							
	Wythenshawe Offices	1 Stancliffe Road, Wythenshawe	M22 4PJ	1334.63	Leasehold	Community Paediatrics, Health Visiting Service, Healthy Schools (PHDS), School Nurses, Speech & Language Therapy, Central GMS (General Managers) Adults, Active Case Management Team, Community Physiotherapy, Continence, Nursing Home Service (Nursing Home Project), Tier 2 COPD, Tissue Viability Citywide Service, Community Manual Handling Team, General Managers, Not Occupied, Infection Control	SLA	NHS PS

ACUTE: UHSM								
ID	**Column 1: Property Name & Address**	**Address**	**Column 2: Postcode**	**Column 3: Area (m2)**	**Column 4: Owned / Leased**	**Column 5: Tenants/Occupiers. Please list**	**Column 6: Lease/Licence/SLA**	**Column 7: Managed by e.g. LIFT**
	Wythenshawe Hospital	Southmoor Road, Wythenshawe, Manchester	M23 9LT	135344	Owned	UHSM Trust services, CMT, MMHSCT, WRVS, League of Friends, South Manchester Healthcare Ltd (and PFI Service Providers), Medicines Evaluation Unit Ltd, Orange/T-Mobile (aerials), Alliance Medical, Anchor Trust, WH Smith, Univserty of Manchester, North West Lung Centre Charity, Manchester and Trafford Social Services, Various Stall Holders	Combination	UHSM

	Withington Community Hospital	Nell Lane, West Didsbury, Manchester	M20 2LR	10112	Owned	UHSM Trust Services, CMFT, Christie, MMHSCT, Care UK, SRFT, PAHT	Combination	UHSM
	Old Withington Hospital Site,	Nell Lane, Withington	M20 2LR	4379	Owned	UHSM Trust Services, MMHSCT	SLA	UHSM
	Buccleuch Lodge	Elizabeth Slinger Road, West Didsbury, Manchester	M20 2XA	1914	Owned	UHSM Trust Services	N/A	UHSM
ACUTE: PENNINE								
ID	**Column 1: Property Name & Address**	**Address**	**Column 2: Postcode**	**Column 3: Area (m2)**	**Column 4: Owned / Leased**	**Column 5: Tenants/Occupiers. Please list**	**Column 6: Lease/Licence/SLA**	**Column 7: Managed by e.g. LIFT**
	North Manchester General Hospital	Delaunays Road, Crumpsall, Manchester	M8 5RB	98317	Freehold	Various - mainy PAHT	N/A	
CMFT (TCS Properties)								
ID	**Column 1: Property Name & Address**	**Address**	**Column 2: Postcode**	**Column 3: Area (m2)**	**Column 4: Owned / Leased**	**Column 5: Tenants/Occupiers. Please list**	**Column 6: Lease/Licence/SLA**	**Column 7: Managed by e.g. LIFT**
	144 Wythenshawe Road	Northern Moor	M23 0PF	191.74		District Nursing, Nutrition, Funded Care Team, Podiatry		
	Abbey Hey Clinic	Constable Street, Abbey Hey, Gorton	M18 8GD	122.08		District Nursing, Nutrition, Funded Care Team, Podiatry		
	Alexandra Park Health Centre	2 Whitswood Close, Alexandra Park, Manchester	M16 7AP	233.64		Continence, District Nurses, Falls, Nutrition, Physiotherapy, Podiatry		
	Ancoats Primary Care Centre	Old Mill Street, Ancoats	M4 6EB	149.46				
	Baguley Clinic	Hall Lane, Wythensawe	M23 1NA	183.56				
	Brownley Green Primary Care Centre	Brownley Road, Wythenshawe	M22 9UH	178.75		Dental		

Burnage Health Centre	347 Burnage Lane, Burnage	M19 1EW	94.35		District Nurses, Nutrition, Funded Care Team, Podiatry			
Camberwell Park School	Specialist Support School, Bank House Road, Blackley, Manchester	M9 8LT	9.38					
Charlestown Road Health Centre	Charlestown Road, Blackley	M9 7ED	135.18		Continence			
Cheetham Hill Primary Care Centre	244 Cheetham Hill Road, Manchester	M8 8UP	296.92		Contraception & Sexual Health			
Chorlton Health Centre	1 Nicholas Road, Chorlton	M21 9NU	246.97		Active Case Manager, Continence, District Nurses, Dental			
Clayton Health Centre	89 North Road, Manchester,	M11 4EJ	82.65					
Cornerstone Centre	2 Graham Street, Beswick	M11 3AA	418.52		Dental			
Crescent Bank	Humphrey Street, Crumpsall	M8 9JS	612.47		Manchester Learning Disability Partnership			
Enterprise House			62.52					
Forum Health	Rowlandsway, Wythenshawe	M22 5RX	184.68		Contraception & Sexual Health, Dental			
Gorton Clinic	Blackwin Street, Gorton	M12 5JY	426.11		District Nurses, Nutrition, Funded Care Team, Podiatry			
Harpurhey Health Centre	1 Church Lane, Harpurhey, Manchester	M9 4BE	194.68		Contraception & Sexual Health, Dental			
Levenshulme Health Centre	Dunstable Street, Levenshulme	M19 3BX	401.24		Directorate Management Team, Active Case Management, Continence			
Longsight Health Centre	526/528 Stockport Road, Longsight	M13 0RR	536.24		Continence, Dental, Ear Nose & Throat, Nutrition, Physiotherapy			

Moss Side Health Centre	Monton Street, Moss Side	M14 4GP	467.67						
Newton Heath Health Centre	2 Old Church Street, Newton Heath	M40 2JF	218.26		Dental				
Newton Silk Mill	10 Holyoak Street, Newton Heath	M40 1HA	50.98		District Nurses, Nutrition, Funded Care Team, Podiatry				
Newton Silk Mill	Holyoak Street, Newton Heath	M40 1HA	130.97						
Northenden Health Centre	489 Palatine Road, Northenden, Manchester	M22 4DH	185.29		District Nurses, Nutrition, Funded Care Team, Podiatry				
Old Withington Hospital Site,	Cavendish Road, West Didsbury	M20 2LR	78.5		Macmillan				
On Heath Centre			117.64						
Plant Hill Clinic	Plant Hill Road, Blackley	M9 8LX	162.69		Dental				
Rusholme Health Centre	Walmer Street, Rusholme	M14 5NP	383.2		Continence, Nutrition, Physiotherapy, Podiatry				
Vallance Centre	Brunswick Street, Manchester	M13 9UJ	405.77		Continence, District Nurses, Nutrition, Physiotherapy, Podiatry				
Victoria Mill	Victoria Mill Health Care Centre, 10 Lower Vickers Street, Miles Platting	M40 7LJ	63.87						
Withington Clinic	535 Wilmslow Road, Withington	M20 4BA	95.91		Speech & Language Theraphy, Dental				
Withington Community Hospital	Burton Road, West Didsbury	M20 2LR	735.22		Clinical Offices				

	Wythenshawe Offices	1 Stancliffe Road, Wythenshawe	M22 4PJ	341.29		Paediatrics, Health Visiting, School Nurses, Speech & Language Therapy		
MENTAL HEALTH								
ID	**Column 1: Property Name & Address**	**Address**	**Column 2: Postcode**	**Column 3: Area (m2)**	**Column 4: Owned / Leased**	**Column 5: Tenants/Occupiers. Please list**	**Column 6: Lease/Licence/SLA**	**Column 7: Managed by e.g. LIFT**
	Chorlton House	70 Manchester Road, Chorlton-cum-Hardy, Manchester	M21 9UN	1,820	Leasehold	Head Office	Private Landlord	MMHSCT Estates
	Park House	North Manchester General, Delaunays Road, Crumpsall	M8 5RB	4,919	Land occuppied under 125 year ground lease	Acute Hospital	n/a	MMHSCT Estates
	Sir Sidney Hamburger	North Manchester General, Delaunays Road, Crumpsall	M8 5RB	624	Land occuppied under 125 year ground lease	Crisis Resolution and Inpatient Services	n/a	MMHSCT Estates
	Psychology Department	North Manchester General, Delaunays Road, Crumpsall	M8 5RB	658	Land occuppied under 125 year ground lease	Psychology Services	n/a	MMHSCT Estates
	Therapy Centre	North Manchester General, Delaunays Road, Crumpsall	M8 5RB	245	Land occuppied under 125 year ground lease	Tribunal rooms	n/a	MMHSCT Estates
	MacCartney House	Beechmount, Rochdale Road, Harpurhey	M9 5XS	1,037	Freehold	Community Team	n/a	MMHSCT Estates

	Recovery Education Centre / Med Education	North Manchester General, Delaunays Road, Crumpsall	M8 5RB	681	Land occuppied under 125 year ground lease	Education and Rehabilitation	n/a	MMHSCT Estates
	Horticultural Department	North Manchester General, Delaunays Road, Crumpsall	M8 5RB	42	Land occuppied under 125 year ground lease	Gardening Therapy	n/a	MMHSCT Estates
	Harpurhey Day Centre	93 Church Lane, Harpurhey, Manchester	M9 5BG	593	s75 Agreement	Day Centre	s75 with MCC re partial occupation	MCC
	Harpurhey District Office	8 Moston Lane, Harpurhey, Manchester	M9 4DP	206	s75 Agreement	Community Team	s75 with MCC re partial occupation	MCC
	Wilson House	Monsall Road, Newton Heath, Manchester	M40 8WN	104	Licence to occupy	Assertive Outreach North	licence for part occupation in place with MIND	MIND
	Hexagon Towers	Delaunays Road, Blackley, Manchester	M9 8GQ	975	Leasehold	Mixed office accommodation	Private Landlord	MMHSCT Estates
	50 Manchester Road	Chorlton cum Hardy, Manchester	M21 9PH	230	Leasehold	Community Team	Private Landlord	MMHSCT Estates
	Rawnsley Building	MRI, Oxford Road, Manchester	M13 9WL	2,652	User Rights	Outpatients and Crisis Resolution	CMFT	CMFT via SLA
	Gaskell House	Swinton Grove, Manchester	M13 0EU	866	Licence to occupy	Psychology Services	CMFT	CMFT via SLA
	High Elms	Upper Park Road, Victoria Park, Manchester	M14 5RU	975	Licence to occupy	Art Therapy and Community Team	CMFT	CMFT via SLA
	Anson Road	3 and 3A Anson Road, Victoria Park	M14 5BY	809	Leasehold	Rehabilitation	CMFT	CMFT via SLA
	Chest Clinic (ground floor)	352 Oxford Road,	M13 9NL	45	Licence to occupy	Homeless Team	CMFT	CMFT via SLA

	Manchester			Leasehold	Community Team	Lease in place for partial occupance with BIGLIFE CENTRES	BIGLIFE centres
	Kath Locke Centre	123 Moss Lane East, Hulme, Manchester	M15 5DD	123			
	Claremont Resource Centre	Rolls Crescent, Hulme, Manchester	M15 4FS	s75 Agreement 48	Network Team	s75 with MCC re partial occupation	MCC
	Victoria Park Day Centre	70 Daisy Bank Road, Longsight, Manchester	M14 5QN	Leasehold 417	Day Centre	MCC	MCC
	Laureate House	Wythenshawe Hospital, Southmoor Road	M23 9LT	Leasehold 3,613	Acute Hospital	UHSM	UHSM via SLA
	The Stables	Withington Hospital, Nell Lane, Manchester	M20 2LR	User Rights - under transfer agreement 395	Community Team	UHSM	UHSM
	Benchmark	Withington Hospital, Nell Lane, Manchester	M20 2LR	User Rights - under transfer agreement 370	Industrial Therapy	UHSM	UHSM
	Roundhouse	Withington Hospital, Nell Lane, Manchester	M20 2LR	User Rights - under transfer agreement 327	Community Team	UHSM	UHSM
	Hall Lane Resource Centre	Hall Lane, Wythenshawe, Manchester	M23 1WD	s75 Agreement 293	Community Team	s75 with MCC re partial occupation	MCC
	Brian Hore Unit	Nell Lane, West Didsbury, Manchester	M20 2LR	Freehold 293	Alchohol Service		NHS PS
	Minehead Resource Centre	Dermot Murphy Close, Withington, Manchester	M20 1FW	s75 Agreement 175	Older Age Day Centre	s75 with MCC re partial occupation	MCC
	Kingslea House	Unit 1, Francis Road,	M20 4XP	s75 Agreement 422	Community Team	MCC	MCC

	Withington							
	Studio 1	St Andrew's Church, Brownley Road, Manchester	M22 0DW	114	Licence to occupy	Art Therapy	Private Landlord	
	Ardeevan House	136 St Werburghs Road, Chorlton cum Hardy, Manchester	M21 8UQ	175	Licence to occupy	Assertive Outreach South / Central	licence for part occupation in place with MIND	MIND
	Abbey Hey Clinic	Constable Street, Abbey Hey, Manchester	M18 8GD	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Alexander Park Health Centre	2 Whitswood Close, Moss Side, Manchester	M16 7AP	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Ancoats Primary Care Centre	Old Mill Street, Ancoats, Manchester	M4 6EB	20	Leasehold	Public Health Development Service	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Belle Vue Leisure Centre	Kirkmanshulme Lane, Belle Vue, Manchester	M12 4TF	20	User Rights	Community Health Trainer	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Brownley Green Primary Care Centre	171 Brownley Lane, Benchill, Manchester	M22 9UH	20	Leasehold		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Burnage Health Centre	347 Burnage Lane, Burnage, Manchester	M19 1EW	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Burnage Media Arts College	Burnage Lane, Burnage, Manchester	M19 1ER	20	User Rights	Community Health Trainer	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Charlestown Road Health Centre	Charlestown Road, Charlestown, Manchester	M9 7ED	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Cheetham Hill Primary Care Centre	244 Cheetham Hill Road, Cheetham Hill,	M8 8UP	20	Leasehold	Primary Care Mental Health	licence fror part occupation in place with NHS PS (BTA)	NHS PS

	Manchester			Licence to occupy	Community Alcohol Team	licence fror part occupation in place with NHS PS (BTA)	NHS PS
Chest Clinic (first floor)	352 Oxford Road, Manchester	M13 9NL	135				
Chorlton Health Centre	1 Nicolas Road, Chorlton cum Hardy, Manchester	M21 9NJ	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
Clayton Health Centre	89 North Road, Clayton, Manchester	M11 4EJ	20	Licence to occupy	PARS Team; Primary Care Mental Health Team; Oral Health Improvement Team	licence fror part occupation in place with NHS PS (BTA)	NHS PS
Cornerstone Centre	2 Graham Street, Beswick, Manchester	M11 3AA	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
Crumpsall SureStart Centre	Cromhurst Street, Crumpsall, Manchester	M8 5FN	20	User Rights	Community Health Trainer	licence fror part occupation in place with NHS PS (BTA)	NHS PS
Fallowfield Library (first floor)	Platt Lane, Fallowfield, Manchester	M14 7FB	380	Leasehold	Public Health Development Service	MCC	MCC
Forum Health	Rowlands Way, Wythenshawe, Manchester	M22 5RX	20	Leasehold		licence fror part occupation in place with NHS PS (BTA)	NHS PS
Fulmead SureStart Centre	Fulmead Walk, Cheetham, Manchester	M8 9DW	20	User Rights	Community Health Trainer	licence fror part occupation in place with NHS PS (BTA)	NHS PS
Harpurhey Health Centre	1 Church Lane, Harpurhey, Manchester	M9 4BE	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
Hexagon Tower (MCC area)	Delaunays Road, Blackley, Manchester	M9 8GQ	20	Licence to occupy	Public Health Development Service	licence fror part occupation in place with NHS PS (BTA)	NHS PS
Higher Openshaw Primary Care Centre	Ashton Old Road, Openshaw, Manchester	M11 1JG	20	Leasehold		licence fror part occupation in place with NHS PS (BTA)	NHS PS
Kath Locke Centre	123 Moss Lane East, Hulme,	M15 5DD	20	Licence to occupy		licence fror part occupation in place with	NHS PS

		Manchester					NHS PS (BTA)	
	Levenshulme Health Centre	Dunstable Street, Levenshulme, Manchester	M19 3BX	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Longsight District Office	521 Stockport Road, Manchester	M12 4NE	20	s75 Agreement	Community Alcohol Team	s75 with MCC re partial occupation	MCC
	Longsight Health Centre	526/528 Stockport Road, Longsight, Manchester	M13 0RR	20	Licence to occupy			NHS PS
	Manchester Tennis and Football Centre	Sports City, Eastlands, Gate 2, Alan Turing Way, Manchester	M11 3FF	20	User Rights	Community Health Trainer		
	Moss Side Health Centre	Monton Street, Moss Side, Manchester	M14 4GP	20	Licence to occupy	Oral Health Improvement Team	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Newton Heath Health Centre	2 Old Church Street, Newton Heath, Manchester	M40 2JF	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Newton Silk Mill	10 Holyoak Street, Newton Heath, Manchester	M40 1HA	20	Licence to occupy	Chronic Fatigue Programme	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	North City Family and Fitness Centre	Upper Conran Street, Harpurhey, Manchester	M9 4DA	20	User Rights	Community Health Trainer	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	North Manchester General Hospital	Delaunays Road, Crumpsall, Manchester	M8 5RB	20	Licence to occupy	Public Health Development Service	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Northenden Health Centre	489 Palentine Road, Northenden, Manchester	M22 4DH	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS

	Plant Hill Clinic	Plant Hill Road, Blackley, Manchester	M9 8LX	20	Licence to occupy		licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Rusholme Health Centre	Walmer Street, Rusholme, Manchester	M14 5NP	20	Licence to occupy	Primary Care Mental Health	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	Strangeways Prison	1 Southall Street, Manchester	M60 9AH	20	Licence to occupy	Prison Health and GP Service; Public Health Development Service	licence fror part occupation in place with NHS PS (BTA)	NHS PS
	The Cliff Training Ground	Lower Broughton Road, Salford	M7 2HU	20	User Rights	Community Health Trainer	NHS PS	NHS PS
	Tree of Life Centre	St Mark's URC, Oatlands Road, Woodhouse Park, Manchester	M22 1AH	20	User Rights	Community Health Trainer	NHS PS	NHS PS
	Vallance Centre	Brunswick Street, Chorlton on Medlock, Manchester	M13 9UJ	20	Leasehold		NHS PS	NHS PS
	Victoria Mill	10 Lower Vickers Street, Miles Platting, Manchester	M40 7LJ	20	Licence to occupy	Public Health Development Service	NHS PS	NHS PS
	Windrush Millenium Centre	70 Alexander Road, Moss Side, Manchester	M16 7WD	20	Licence to occupy	Public Health Development Service	NHS PS	NHS PS
	Withington Centre	535 Wilmslow Road, Withington, Manchester	M20 4BA	20	Licence to occupy		NHS PS	NHS PS
	Withington Community Hospital	Nell Lane, West Didsbury, Manchester	M20 2LR	20	Licence to occupy	Public Health Development Service	NHS PS	NHS PS
	Withington Leisure Centre	Burton Road, Withington, Manchester	M20 3EB	20	User Rights	Community Health Trainer	NHS PS	NHS PS

Woodville SureStart Centre	Shirley Road, Cheetham, Manchester	M8 0NE	20	User Rights	Community Health Trainer	NHS PS	NHS PS	
Wythenshawe Offices	1 Stancliffe Road, Wythenshawe, Manchester	M22 4PJ	20	Licence to occupy	Primary Care Mental Health	NHS PS	NHS PS	

Appendix B7 – Abbreviations

Abbreviation	Meaning
ADASS	Association of Directors of Adult Social Services
BBC	British Broadcasting Corporation
CCG	Clinical commissioning group
CHP	Community Health Partnerships
CMCCG	Central Manchester Clinical Commissioning Group
EMIS	Egton Medical Information Systems
eWIN	Electronic Workforce Information Network
DN	Drafting note
GP	General practitioner
HEE	Health Education England
IG	Information governance
IM&T	Information management and technology
IT	Information technology
LETB	Local Education and Training Board
LIFT	Local Investment Finance Trust
LTC	Long-term condition
MCC	Manchester City Council
MMHSCT	Manchester Mental Health and Social Care Trust
NHS	National Health Service
NHSPS	National Health Service Property Services Ltd
NMCCG	North Manchester Clinical Commissioning Group
NMDS-SC	National Minimum Data Set – Social Care
NWAS	North West Ambulance Service NHS Trust
Org.	Organisation
PAHT	Pennine Acute Hospitals NHS Trust
PCT	Primary Care Trust
SHA	Strategic health authority
SLA	Service level agreement
SMCCG	South Manchester Clinical Commissioning Group
UK	United Kingdom

Appendix B8 - References

[1] 2011 Census: Health and provision of unpaid care, local authorities in England and Wales Source (Office for National Statistics)

[2] Morris Hargreaves McIntyre, Research on the Children and Young People's Plan (May, 2009)

[3] Skills for Care & ADASS, Practical approaches to workforce commissioning – *Resources to support the development of integrated local area workforce strategies* (Leeds, 2012) www.skillsforcare.org.uk www.adass.org.uk