**Manchester Health and Wellbeing Board**
**Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 6 November 2013

**Subject:** Living Longer Living Better, Strategic Business Case

**Report of:** City Wide Leadership Group

## Summary

This report articulates the high level strategic business case to take forward a radical programme of community based coordinated care in Manchester, the Living Longer Living Better programme.

This strategic business case builds on the Living Longer Living Better Blueprint submitted in March 2013 and the Strategic Outline Case submitted in June 2013. In particular, it:

- Re-affirms the case for change and the rationale for the Living Longer Living Better programme.
- Describes for the first time a much deeper understanding of the different population groups in Manchester, highlighting how different population groups access and use different health and social care services across different commissioners and providers in the city.
- Details the care models that are in development for the priority population groups in the city, articulating the macro changes required in how and where we deliver health and social care services, including the practical 'big ticket' items that we will focus on in the short term to make out of hospital care a reality on the ground.
- Provides the high level financial case for change and the forecast impact of the priority care models within the Living Longer Living Better programme, across commissioners, providers, population groups and settings of care.
- Details the progress to date against the practical implementation priorities across the workstreams established under the Living Longer Living Better programme, including contracting arrangements, development of new delivery models within each care model, the development of an evaluation framework and work on the underpinning enablers of the Programme, such as estates and workforce.

This strategic business case is a key milestone in the development of the Living Longer Living Better Programme. Significant progress has been made since the Strategic Outline Case. It represents one of the most comprehensive and ambitious health and social care reform programmes in the country. Our understanding of the 'as is', the creation of innovative new care models and the development of granular financial models means that we are well placed to make informed investment decisions going forward.

But this strategic business case is only the end of the beginning. Over the next five months significant leadership commitment will be required if we are to move from this high level strategic business case to practical delivery (and impact) on the ground.

We now need to shift our attention from the what and why to the how and when. The implementation section of this strategic business case describes in practical terms how we will do this.

**Recommendations**

The Board is asked to:

- Approve the contents of this report and the initial analysis of the population groups, the description of the priority care models and the high level financial case, whilst understanding that further work will be required to refine this data.
- Approve the proposed next steps as described within the implementation section, with particular reference to the development of new contracting and delivery models and the timescales attached
- Note the limitations of the financial case because of the available data and evidence, but recognise we have significantly increased our understanding and have a clear risk mitigation plan in place to make informed investment decisions going forward.
- Agree to receive a further progress report in January 2014.

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**Board Priority(s) Addressed:**

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

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

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**Background documents (available for public inspection):**

The Blueprint for Living Longer Living Better was set out in '*Living Longer Living Better, An Integrated Care Blueprint for Manchester*', presented to the Health and Wellbeing Board in March 2013.

This was followed by the 'Living Longer Living Better Strategic Outline Case' presented to the Health and Wellbeing Board in June 2013, which described in more detail the three main areas or 'domains' of the city's plans for integrated care.

## Contents

## Executive Summary

Manchester is a vibrant, dynamic city with a growing population. However, the health outcomes of our population are poor and lag behind other parts of the country. The city has the worst life expectancy for women and the second worst for men in England. The prevalence of long term conditions such as diabetes, chronic obstructive pulmonary disease and heart disease is higher than the England average; deaths from circulatory disease are almost double the average.

The quality of and access to health and social care services are variable, with care provision often fragmented and uncoordinated across the city, and the use of the acute sector for the delivery of services is high relative to the national average, with people ending up in hospital for want of alternative community provision. This too often results in patients receiving reactive care to urgent needs instead of earlier, planned and more cost-effective intervention.

Fiscal and demand pressures compound the case for change. The overall financial envelope for the health and social care system is forecast to reduce by £164m or 17% to 2017/18, with demographic pressures expected to compound the challenges faced by the system over the same period.

It is against this context that the Living Longer Living Better Programme was established in March 2013, building on the existing collaborative approach between commissioners and providers across the health and social care systems in North, Central and South Manchester.

The Living Longer Living Better programme is a bold and ambitious programme to deliver world class community based coordinated care for Manchester's residents. Not only to the 1-2% with the most complex and costly health needs today, but the population as a whole.

This strategic business case outlines the vision for Living Longer Living Better; our understanding of the target population groups in Manchester; the care models we need for the priority population groups; the development of the high level financial case for investment in the new care models; and the key implementation actions that are underway to move the Living Longer Living Better programme from strategy and intent into practical delivery.

We now understand in a far more granular way than ever before the way in which the health and social care system and different population groups interact in Manchester today. For example, the cost of each population group, across each setting of care, both in terms of cost and volume.

From this more sophisticated understanding of population group needs, we have developed innovative new care models that more effectively respond to the needs of our priority population groups. As well as basing our proposals on the best available evidence of what works, the development of care models has been a collaborative, inclusive process. This has involved technical and medical experts, voluntary and community sector organisations and patient representative groups to secure real insight into the future care models we need in Manchester.

The care models articulate at a high level the measurable outcomes required, the care model components which will enable us to achieve those outcomes, and the big ticket deliverables that will be implemented on a phased basis (pending future investment decisions). This includes for example the 'hospice at home' model; one shared care plan and care coordination approach across agencies; and innovative self care and peer support models.

As we have developed our understanding of the population groups and care models, we have been building the financial case for investment in the new care models. The challenge involved in creating a robust investment case for the new care models is a complex one, reflecting the different payment models, contracting arrangements and data capture categorisations used across commissioners and providers in the city.

We now have a financial modelling tool which enables us to forecast the shift in resource across settings of care for the new care models. We are able to model expected impacts of new care models in terms of reductions in demand across commissioners, providers and settings of care.

The current inputs and outputs of the modelling work require significant refining and challenge over the coming months. However, this is very much the first phase in the development of the financial case within a two year programme of financial risk management. As we continue to refine the financial case, as we phase implementation of big ticket items, so our level of understanding will increase, enabling us to replace assumptions with evidence, informing the scaling up (or decommissioning) of new care models.

The initial output of the work is indicating a shift from secondary care of just under £10m annualised impact in 2018/19. This equates to 6% of the budget challenge described above, although it is important to emphasise that Living Longer Living Better is just one element of the health and social care growth and reform plans in the city. To put this in context, if the shift from secondary care equated to lifting Manchester to the national average in terms of non-elective hospital admissions, this would result in a shift of £12.5m, and upper quartile would be £19m for the five priority population sub-groups. Whilst this is a crude measure which doesn't factor in the phasing or realisation of cost savings, it does illustrate the potential opportunity. So as well as the techincal challenge on the assumptions, we need to ask ourselves are we being ambitious enough in terms of the shift of resources required and the likely impact.

Through the Living Longer Living Better programme, we need to be confident in the scale and consistency of out of hospital integrated care models before we implement changes at scale to acute services. Our residents must be able to 'touch and feel' what integrated care means for them, rather than a nebulous concept. Within this strategic business case we present the high level implementation actions such as the new contracting arrangements required to deliver the new care models; the development methodology for the new delivery model 'big tickets' for each care model; stakeholder engagement priorities; and underpinning enablers such as estates required to get the Programme off the ground.

It is important to highlight that the Living Longer Living Better programme is just one part of the growth and reform plans for health and social care in Manchester. We need the best, mutually supportive set of proposals achieving integrated health and social care *and* a safe and financially viable acute sector in Manchester. So as well as high quality, cost effective coordinated care, we must also build Manchester's offer of world class health sciences and health research, which will translate into economic growth for the city.

Ultimately, the implementation of out of hospital community based care has to happen at scale and speed if we are to meet the fiscal and demand challenges facing Manchester, at the same time as making informed investment decisions that balance risk and reward.

This will not be easy. As we shift our focus to the 'how' rather than the 'what and why', we will face capacity challenges, different cultures and competing priorites. We will need to shift Living Longer Living Better from a programme developed by the few to a movement owned by the many. But we have the collaborative leadership in place, the ambition and the talent in the city to make the Living Longer Living Better vision of world class community based coordinated care a reality.

## 1.0 Introduction and background

1.0.1 Our goal in Manchester is for our population to be living longer and living better, which is the name we have given to our integrated health and care programme. This is one part of the growth and reform plans within health and social care in the city.

1.0.2 In 2010 the major health and social care commissioners and providers in the city came together to develop integrated care proposals, recognising that only by working collaboratively across traditional silos will be able to deliver better outcomes within a very different fiscal climate.

1.0.3 In 2012 Manchester developed a range of integrated working pilots in the three health economies in Manchester, testing new integrated care delivey models that joined up primary, community, social and secondary care services around patients with the highest needs. Evidence captured from these pilots is now informing the design of the Living Longer Living Better programme.

1.0.4 In March 2013 the Manchester Health and Wellbeing Board (HWB) approved the Blueprint for the Living Longer Living Better programme where we set out our ambition for the city to build out of hospital services, supporting our population with coordinated care, and shifting care from our hospitals.

1.0.5 The Strategic Outline Case (SOC) presented to HWB in June 2013 described extending our integrated care arrangements to the whole Manchester population, with some proposals on what this would mean in terms of our people (population), our care models (characterisitics of how care could be organised around outcomes) and our contracting and funding arrangements.

1.0.6 This strategic business case builds on the SOC, describing for the first time a much more granular understanding of:

- The different **population groups** in Manchester that access and use health and social care services. This includes those that are living healthly lives that have limited contact with the health and socail care system to those that have multiple long term conditions with repeated unplanned spells in secondary care.

- The **care models** that as a city we want to commission, detailing the population groups we will prioritise and target, the outcomes we want to achieve and how we will measure success.

- A **cost benefit analysis** that determines current costs, the future financial envelope and trajectory, and the forecast financial impact of the care model proposals.

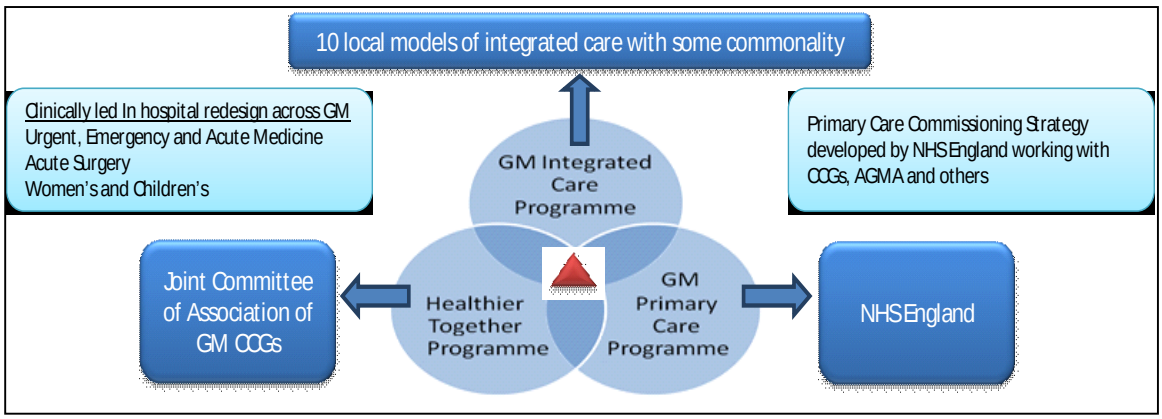
1.0.7 This strategic business case also provides details on the implementation priorities to take forward the programme, including for an example an **evaluation framework** and approach to underpin and ensure robust measurement of agreed outcomes throughout the health and care system.

1.0.8 The table below highlights for reference the key actions articulated within the SOC and progress made against each action.

| Action | Progress? | Narrative |
|---|---|---|
| ***"Gain a more thorough understanding of the city's population and its needs"*** | ✓ | Significant progress made in understanding Manchester's population, how it currently accesses and uses health and social care services and the cost and volumes attached. |
| ***"Test whether the top 20% at risk patients should form the focus for the city's integrated care models"*** | ✓ | Significant progress, covering 100% of the population and segmenting the population by different population groups. Shifted away from a focus on existing high cost, high risk cases to those at risk of escalating need. |
| ***"Identify population segments for care interventions"*** | ✓ | Good progress, 12 population groups defined with clear definitions for each group established. Analysis also undertaken to determine the cost and volume of each population group. |
| ***"Identify the costs of the current care models"*** | ✓ | Significant progress, detailed modelling of the existing costs of care undertaken, split not only by population group but by commissioner, provider and setting of care. |
| ***"Support cost benefit analysis of the new care models"*** | ✓ | Significant progress, for the first time a CBA undertaken for each of the new priority care models, split by population group, commissioner, provider and setting of care. High level analysis reflecting current position within the programme, but strong foundations for the next stage of detailed new delivery model financial modelling. |
| ***"Engage strategic leader for the Living Longer Living Better programme"*** | ✓ | David Fillingham, Chief Executive of AQuA (Advancing Quality Alliance), and his senior team have been engaged to provide strategic leadership support and coaching to the LLLB executive team. |

## 1.1 Greater Manchester Context

1.1.1 The development of the strategic business case for integrated care in Manchester sits within the context of, and is aligned to, the three overlapping and dependent programmes of work at a Greater Manchester level, as shown pictorially below.




*GM Integrated Care Programme: Local Models of Integrated Care*

1.1.2 Rapid progress is being made in developing 10 x local models of integrated care including working examples in places and implementation of new service models backed by emerging contracting and financial arrangements. Promoting independence and resilience is embedded in these models and they are beginning to demonstrate the way in which local services will actually look and feel to patients/residents/carers. These models are being constructed on a local partnership basis and effectively led through all 10 local Health and Wellbeing Boards.

### *Primary Care*

1.1.3 In each of three CCG areas in Manchester, new models of primary medical care provision are being developed within the GM primary care programme. These are variations on a federated model of general practice across the patch. These will have three key aims. Firstly to increase the scope of services that can be delivered through primary care. Secondly to bring consistency of primary care as part of the system and finally to bring a representative provider voice to primary care.

1.1.4 Central Manchester has successfully bid against a fund held by the Greater Manchester Area Team to support the mobilisation and development of primary care, particularly through integration. This provides the opportunity to promote and test a number of initiatives which are essential for our developing integrated care systems such as improved access, improved patient engagement, and improved care for those with particular needs.

1.1.5 A city wide reference group for primary care development will ensure learning and best practice are shared across the localities.

### *Healthier Together*

1.1.6 The reconfiguration of hospital services in GM that need a GM planning perspective has been at the heart of the work led by the NHS in GM and recognised as “Healthier Together”. The driver for this work is that currently outcomes from some hospital services for GM residents are not consistently delivering against highest quality and safety criteria and financial sustainability is not secured.

1.1.7 Progress is being made in designing models of care that meet best practice clinical standards, and in understanding current clinical interdependencies within hospital sites that will inform the reconfiguration and influence the provision of services carried out in the Primary Care and Integrated care programmes. The Healthier Together programme is formally managed by the GM CCGs, who through the formation of a ‘Committee in Common’ will lead the public consultation and will make a decision on the future configuration of hospital services in GM.

1.1.8 These three programmes are being managed effectively as a single programme, bound by a common underpinning leadership narrative, public facing narrative, aligned programme planning and key stakeholder management strategy.

## 2.0 The case for change

2.0.1 Manchester is a vibrant, dynamic city with a growing population. However, the health outcomes of our population are poor and lag behind other parts of the country. The city has the worst life expectancy for women and the second worst for men in England. The prevalence of long term conditions such as diabetes, chronic obstructive pulmonary disease and heart disease is higher than the England average; deaths from circulatory disease are almost double the average.

2.0.2 A study into health and social care commissioned in 2012 found that the health and social care system in Manchester required considerable change. The quality of and access to services are variable, with care provision often fragmented and uncoordinated across the city, and the use of the acute sector for the delivery of services is high relative to the national average with people ending up in hospital for want of alternative community provision. This too often results in patients receiving reactive care to urgent needs instead of earlier, planned and more cost-effective intervention.

2.0.3 The drivers for change raised in the study can be summarised as twofold. First, the complex, fragmented system we have today is not working for individuals and not delivering the improvements in lives and health outcomes. Second, the current system, which relies heavily on care delivered in hospitals is not financially sustainable in the future. We need a system that delivers more care closer to home and fosters people's independence.

### 2.1 A complex, fragmented system

2.1.1 Progress has been made in recent years in delivering more integrated, coordinated care. The creation of the three Clinical Commissioning Groups in Manchester has created a sea change in how commissioning is undertaken and there is now greater clinical dialogue within the system and greater input into decision making by grass root GPs. In a further step, all community services provided by NHS Manchester were transferred in 2011 to the three main acute hospitals, with the aim of delivering more care in the community.

2.1.2 However the system remains fragmented and citizens of Manchester often experience difficulty understanding and navigating the current service models. Health and social care services work independently, with distinct strategies and approaches to services. This has resulted in the inequality of service offer and quality to develop across the health and care system in the city. For example, patients that live outside the city boundaries but are registered with Manchester GPs are eligible for health services in the city but not eligible for social care services, which are provided by neighbouring local authorities.

2.1.3 On the ground, Manchester's citizens live in a city with a vast range of health and social care access points. We have four hospital trusts with a range of buildings, 98 GP Practices on numerous sites, a city council contact centre, 50 community centres, and 6 social care district offices. Historically most of our

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

2.1.4 The fragmented system also results in individual conditions being treated, rather than the whole needs of the person. In particular the mental health needs of patients with long term physical conditions are often under dignosed and addressed. It places hospitals at the centre, with providers working in silos (with adhoc collaboration) and staff working reactively to meet needs typically arising from specific urgent health or care events. With an increasingly ageing population and more people living longer with greater ill health, the current fragmented and reactive system is no longer fit for purpose – if not reshaped it will continue to be high cost and delivering poor outcomes for Manchester people. We need an integrated system that is centred around the individual.

## 2.2 Financial sustainability

2.2.1 The second key driver for change is financial sustainablity and Section 6 in this Strategic business case sets out the projected financial envolope and the scale of the financial challenge. Critically, the current health and social care system is unaffordable in the future. We need a system that shifts demand and resource away from hospitals and promotes independence and self-care.

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

2.2.3 Good progress has been made in recent years with local adaptation to contracts, cross agency funding and different reimbursement solutions put in place. These have been shown to be real enablers for change. However, we need to put in place a more ambitious model to achieve a new care system in Manchester. Section 7 sets out the developments to date on contracting and the next steps for implementing change.

2.2.4 To conclude, our aim is to 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. It means co-ordinating care around the individual, removing the barriers that users face when accessing health and social care, providing care (including earlier intervention) at the most appropriate location and supporting independence.

## 3.0 The narrative and vision for Living Longer Living Better

3.0.1 Taking the case for change and the GM context into account, including Healthier Together and Primary Care, there is a clear narrative for the Living Longer Living Better Programme which sets out the rationale for our approach, outlined below.

i. Integrated health and social care is one part of the growth and reform plans in Manchester. As well as a coherent out of hospital offer for our residents, we must also build Manchester's offer of world class health sciences and health research, which will translate into economic growth for the city.
ii. Integrating health and social care, and dealing with the financial and clinical challenges of the acute sector is complex, sensitive and time consuming. But it is inherent to our ambition for the city and its residents, and is best led by Manchester rather than being imposed.
iii. There is a "burning platform" of significant reductions in Council and NHS funding at a time of increasing demand pressures. "Do nothing" is not an option.
iv. We need the best, mutually supportive set of proposals achieving integrated health and social care *and* a safe and financially viable acute sector in Manchester.
v. There needs to be confidence in the scale and consistency of out of hospital integrated care models before we implement changes at scale to acute services. Our residents must be about to 'touch and feel' what integrated care means for them, rather than a nebulous concept.
vi. Out of hospital integration has to happen at scale and speed if we are to meet the fiscal and demand challenges facing Manchester.
vii. In Manchester we have invested significantly in developing jointly owned and shared plans for out of hospital care – involving not only commissioners but providers, patient groups and the voluntary and community sector. This will help speed the implementation of the new care models.

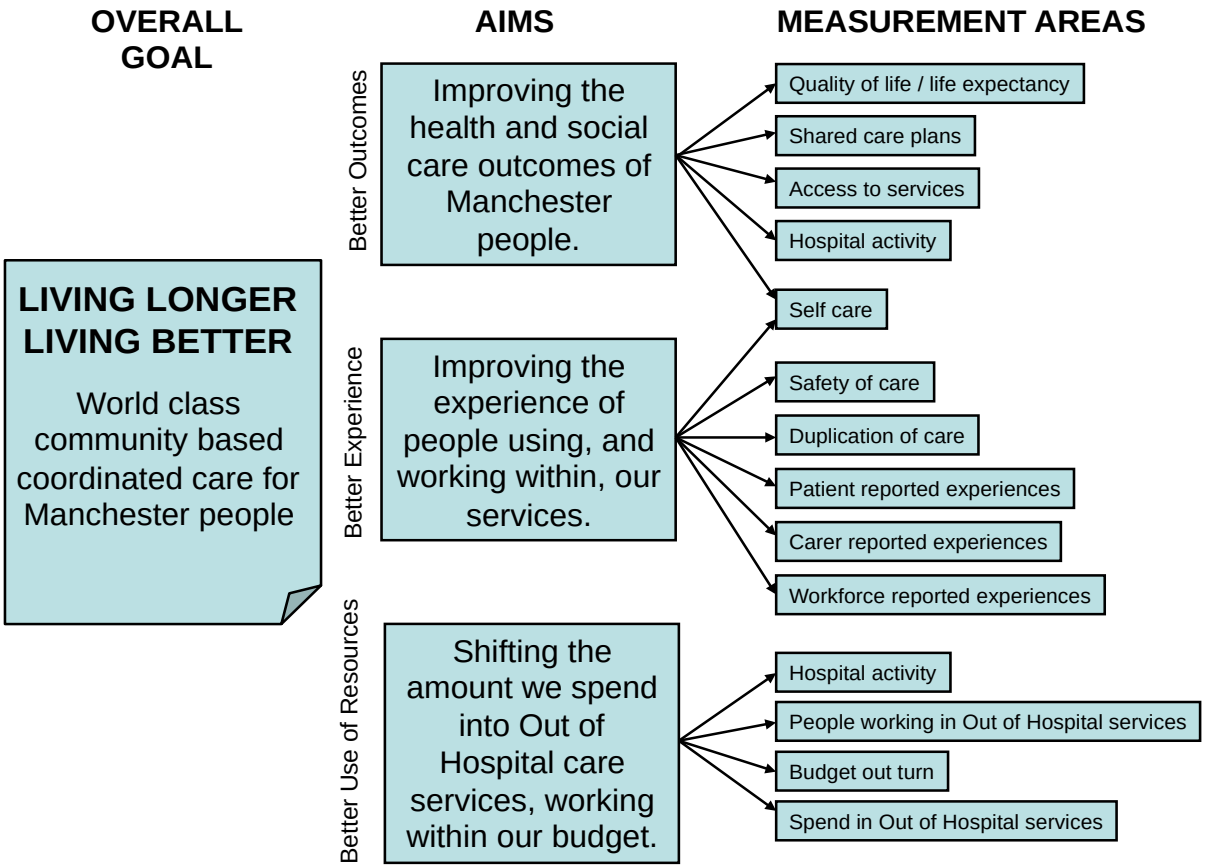
3.0.2 As we have developed the shape and focus of the Living Longer Living Better programme, the key partners in the health and social care have agreed the following principles for the Programme:

- Provide better coordinated person centred care.
- Have measurable improvement in outcomes for our target populations.
- Support care closer to home (right place, right support, right time).
- Actively support the health and care needs of carers.
- Promote independence, health and wellbeing for all Manchester people.
- Develop a health and care system based on the needs of local people not organisations.
- Ensure the system is safe, effective, efficient, affordable and sustainable.

3.0.3 We will deliver this by:

- Empowering and equipping our Workforce with the skills to deliver co-ordinated care.
- Connecting systems and people with up to date information.
- Ensuring we have quality buildings providing multi agency support and care.
- Creating a movement for social change, engaging with the whole Manchester population, to provide a new paradigm for how people view their health.

3.0.4 We have also defined in more detail the overall programme goal, aims and measurement areas – ensuring clarity of purpose and direction across a complex system.




3.0.5 Throughout the development process we have consistently returned to 'what does this mean for residents' and introduced Mrs Pankhurst as a means of articulating the vision for the service on the ground. This is described again for reference below.

## 3.1 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, no longer lost days at school in order to care for John and is able to have time to do his studies and socialise with friends. He is now projected to achieve good grades.

Mary is able to work and care for both her children, Victoria has had a coordinated programme of screening, immunisation and care in her early years and is now ready for secondary school with the potential to do well. Her son has a shared care plan that Mary understands and a coordinated 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 coordinated package of care. He is knowledgeable about where to go and how to manage his addiction and illnesses when necessary.

## 4.0 Our Population

4.0.1 For Living Longer Living Better to be effective we need to identify those people most at risk of escalating care needs, who would benefit from a more coordinated response to enable them to live longer and live better.

4.0.2 We have built up our understanding of the health and social care needs of Manchester's population in a number of phases. In phase one, we segmented the city's population by broad risk cohorts (Very High Risk, High Risk, Moderate Risk, Low Risk of unplanned admissions to secondary care). In phase two we have developed a more sophisticated understanding of the population groups beyond hospital admissions, looking at prevalence, activity and costs across more clearly defined population groups with different characteristics. This section summarises the key outputs of phase one and phase two.

### 4.1 Phase one analysis: Risk stratification

4.1.1 The first step in our analysis has been to sub-divide 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), shown in the diagram below. This shows that the Very High Risk and High Risk patient categories make up just 0.3% and 1.2% of the population respectively. Looking at it another way, an integrated care programme that targeted the 20% or more of patients at the highest risk of admission would draw in people classed by the CPM as being at low or moderate risk of admission.

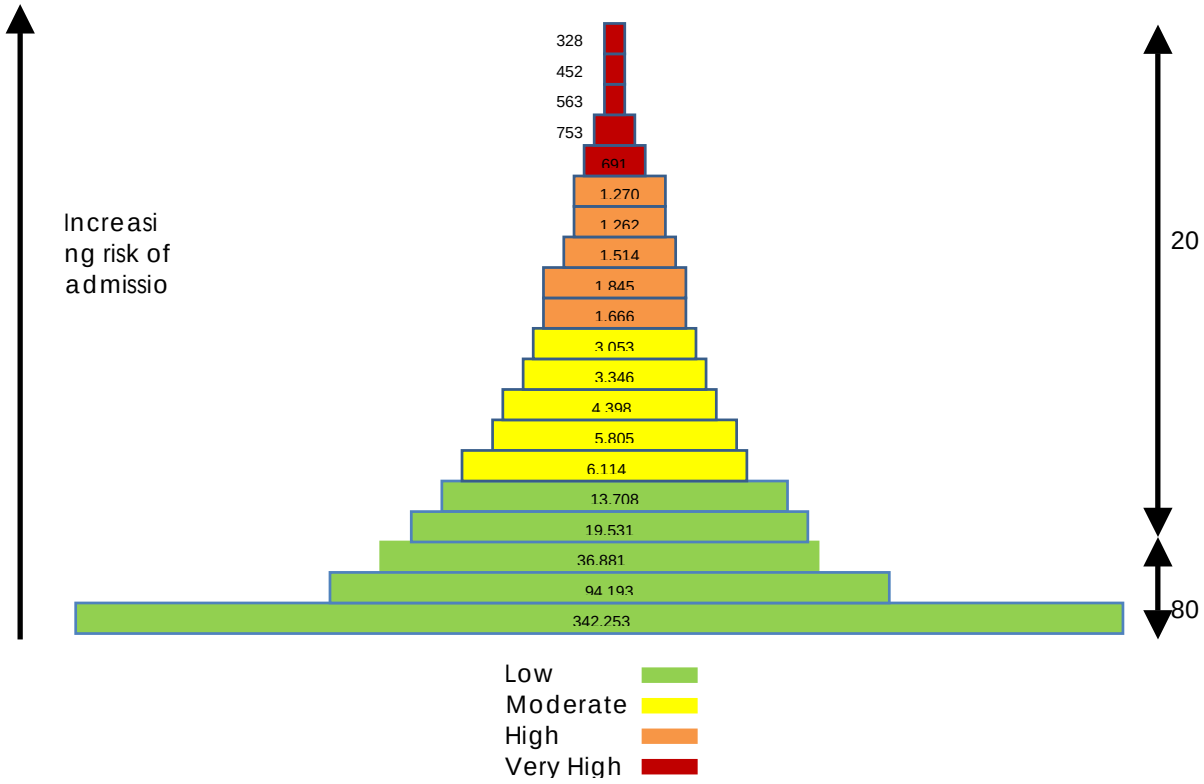


Figure 1: stratified risk pyramid for Manchester's population

4.1.2 The CPM analysis also reveals the diversity within risk cohort and population groups. For example, taking a population group such as older people over 75, we know these are more likely to be in the Very High Risk cohort (2.4% compared with 0.3% for the population as a whole) but the majority (68.3%) are still categorised as low risk. Similarly, each risk cohort contains patients of different ages, with different conditions.

4.1.3 The implication is that using the four risk categories or general population groups (i.e. older people, adults and children) is too blunt an instrument with which to target interventions effectively. The Strategic Outline Case concluded that we need to be clearer about which groups we want to target in order to prevent an increase in patients' risk of hospital admission and enable the population to live longer and live better.

## 4.2 Phase two analysis: Sub-group population analysis

4.2.1 Since the Strategic Outline Case, we have identified eleven population sub-groups with the City Wide Reference Group, which provide a greater level of granularity with which to develop integrated care models. Five of these have been identified as priority groups for the development of the first set of integrated care models. The sub-groups are (*denotes the highest priority sub-populations):

- Adults and children that are at the end of their lives*
- Adults living with long term conditions, illness, disease or disability and are unwell*
- 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 complex lives such as those who are homeless, people with long-term mental health problems, people with addictions or those in troubled families*
- Adults and children who are carers
- Children in their early years 0-4
- Women who have given birth and /or women who have received antenatal services
- Adults in work within our organisations who need to change the way they care
- Older people over 75 who are well
- Adults who are well
- Children (aged 5-18) who are well

4.2.2 The figures presented in this section have been produced for the specific purpose of populating the cost-benefit model referred to elsewhere in the paper. The requirements of this model mean that the population has been split in such a way so as to ensure that each person falls into one sub-group only. The criteria we have used to do this are listed in Table 1 below. This is a

necessary simplification for the modelling of the population and, in reality, a person may span more than one group. In a number of cases, notably end of life care, frail older people / older people with dementia, and children with long term conditions, the method used may have resulted in an under-count of the number of people in each sub-group. These under-counts will also present themselves in the population growth and spend analysis contained in Table 2 and Figure 3. We recognise this fact and are working to resolve this situation.

4.2.3 Although these figures are an acceptable starting point, the process of quantifying the number of people in each sub-group, and the overlaps between them, is an ongoing one and we will continue to work towards a stage where we understand as much about the people within each sub-group as possible. As we gain a better understanding of our populations, we will continually adjust and refine our cost-benefit model so that it is always reflective of our current estimates of the size of the population sub-groups and the impact of the new care models on them.

4.2.4 Consistent with the risk stratification analysis, the vast majority of the population are in the 'good health' category. The five priority sub-groups (excluding the Early Years priority group) account for 107,000 people (18% of the total population), with Adults with Long Term Conditions making up the largest of these (74,000 people, 13% of the total population).

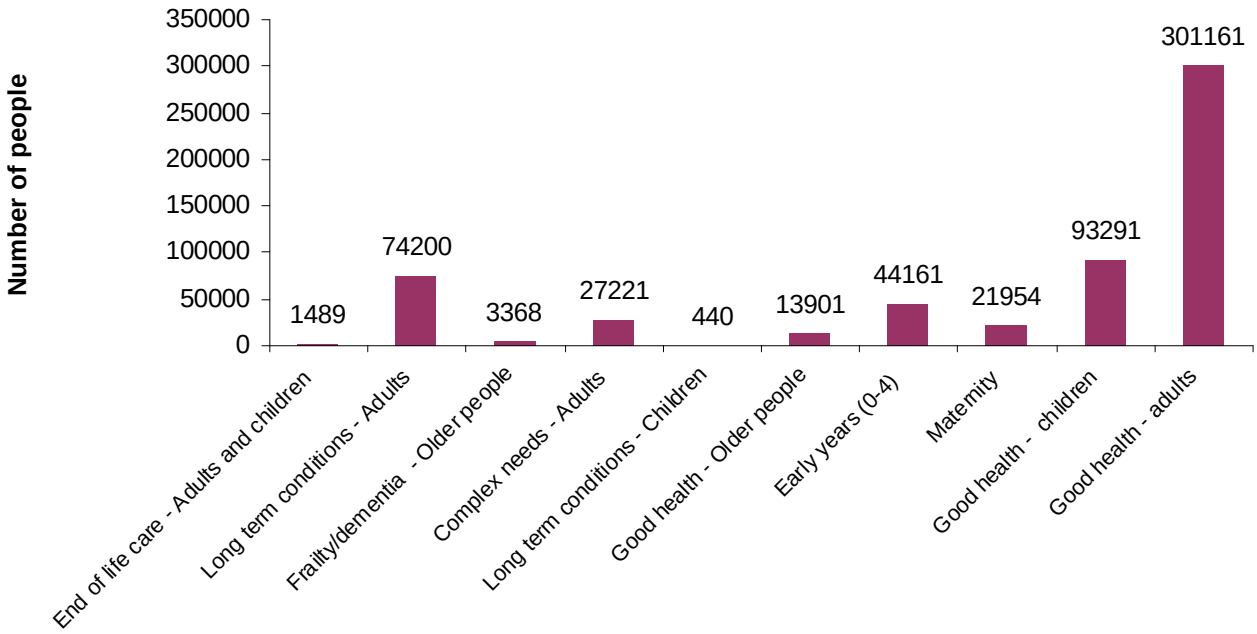



Figure 2: Total population by sub-group in 2013/14

| | Sub-group name | Rules | Dominates over: | Priority groups |
|---|---|---|---|---|
| 1 | **End of life care - Adults and children** | 1. Age: 0+<br>2. On Palliative care register | All | ✓ |
| 2 | **Long term conditions** | 1. Age: 19 years + | Maternity | ✓ |

| | | | | |
|---|---|---|---|---|
| | **- Adults** | 2. On one or more of the LTC register | Good health - Adults<br>Good health - Older people | |
| **3** | **Frailty / dementia - older people** | 1. Age: 65 years +<br>2. Secondary care activity including:<br>- Dementia<br>- Broken bones in the upper body<br>- Falls | LTC - Adults<br>Good health - Older people | ✓ |
| **4** | **Complex needs - Adults** | 1. Age: 19 years +<br>2. Presents two or more of:<br>- Drug abuse<br>- Alcohol abuse<br>- Mental health<br>- Homeless | LTC - Adults<br>Frailty / dementia - Older people<br>Good health - Adults<br>Good health - Older people | ✓ |
| **5** | **Long-term conditions - Children** | 1. Age: 18 years +<br>2. On one or more of the LTC register<br>Note: may not capture learning disability / physical disability | Good health - Children<br>Early years (0-4) | ✓ |
| **6** | **Carers - Adults and children** | N/A for current modelling purposes | N/A | |
| **7** | **Good health - older people** | 1. Age: 65 years +<br>2. Included in no other group | None | |
| **8** | **Early years (0-4)** | 1. Age: 0-4 years<br>2. Included in no other group | None | |
| **8b** | **Maternity** | 1. Women who have given birth<br>2. Women who have received antenatal services | Good health - Children<br>Good health - adults | |
| **9** | **Good health - children** | 1. Age: 5-18 years<br>2. Included in no other group | None | |
| **10** | **Staff - Adults** | N/A for current modelling purposes | N/A | |
| **11** | **Good health - Adults** | 1. Age: 19-64 years<br>2. Included in no other group | None | |

Table 1: Population Sub-Group Definitions

4.2.5 Looking ahead, over the next five years the total population is forecast to increase by 7.3%, with children and early years seeing the highest population growth of 13.8% over the period.

| | 2013/2014 | 2018/2019 | Increase in population |
|---|---|---|---|
| **End of life care - Adults and children** | 1489 | 1572 | 5.6% |
| **Long term conditions - Adults** | 74200 | 78107 | 5.3% |
| **Frailty/dementia - Older people** | 3368 | 3557 | 5.6% |
| **Complex needs - Adults** | 27221 | 28654 | 5.3% |
| **Long term conditions - Children** | 440 | 501 | 13.8% |
| **Good health - Older people** | 13901 | 14681 | 5.6% |
| **Early years (0-4)** | 44161 | 50271 | 13.8% |
| **Maternity** | 21954 | 23110 | 5.3% |
| **Good health - children** | 93291 | 106198 | 13.8% |
| **Good health - adults** | 301161 | 317018 | 5.3% |
| **TOTAL** | 581186 | 623669 | 7.3% |

Table 2: Projected increase in population by subgroup

4.2.6 The five priority groups may only make up just under a fifth of the population but they account for around two-thirds of the total health and social care cost. Figure 3 below shows how this translates into per person costs – we can see that the cost is higher in all the five priority groups. Looking deeper, across the different settings of care (i.e. primary, secondary etc), Adults with Long Term Conditions and Adults with Complex needs make up the largest proportions of spend due to their population size and cost, but the proportions vary, with Adults with Complex Needs making up a large proportion of mental health costs.

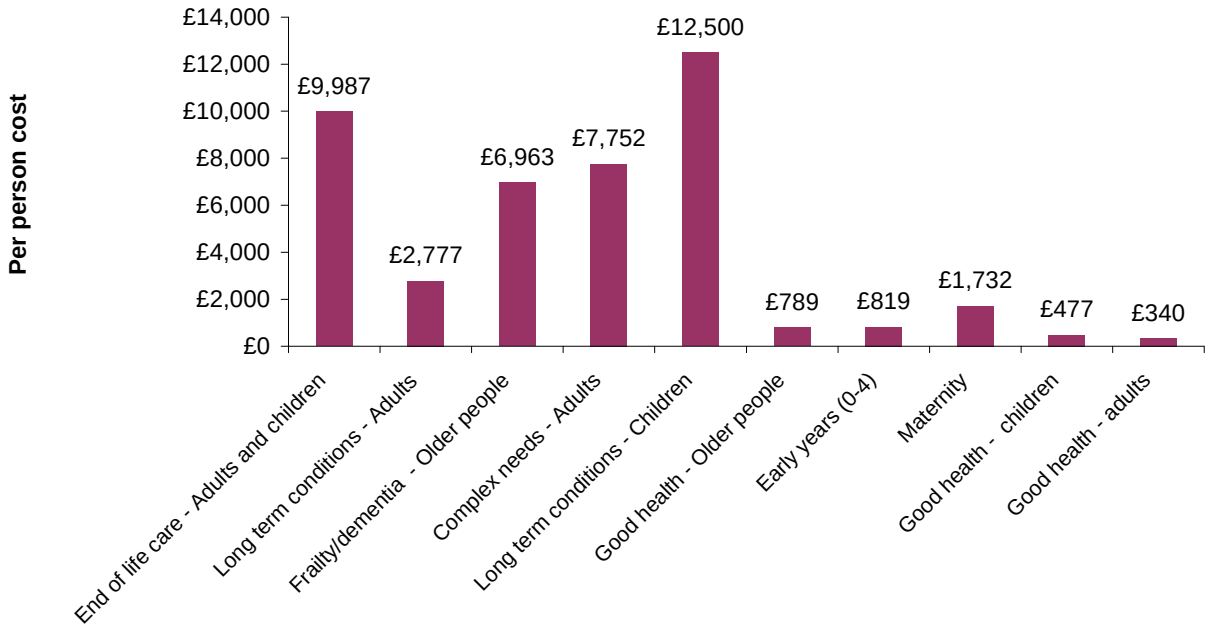



Figure 3: Health and social care cost per capita by population sub-group

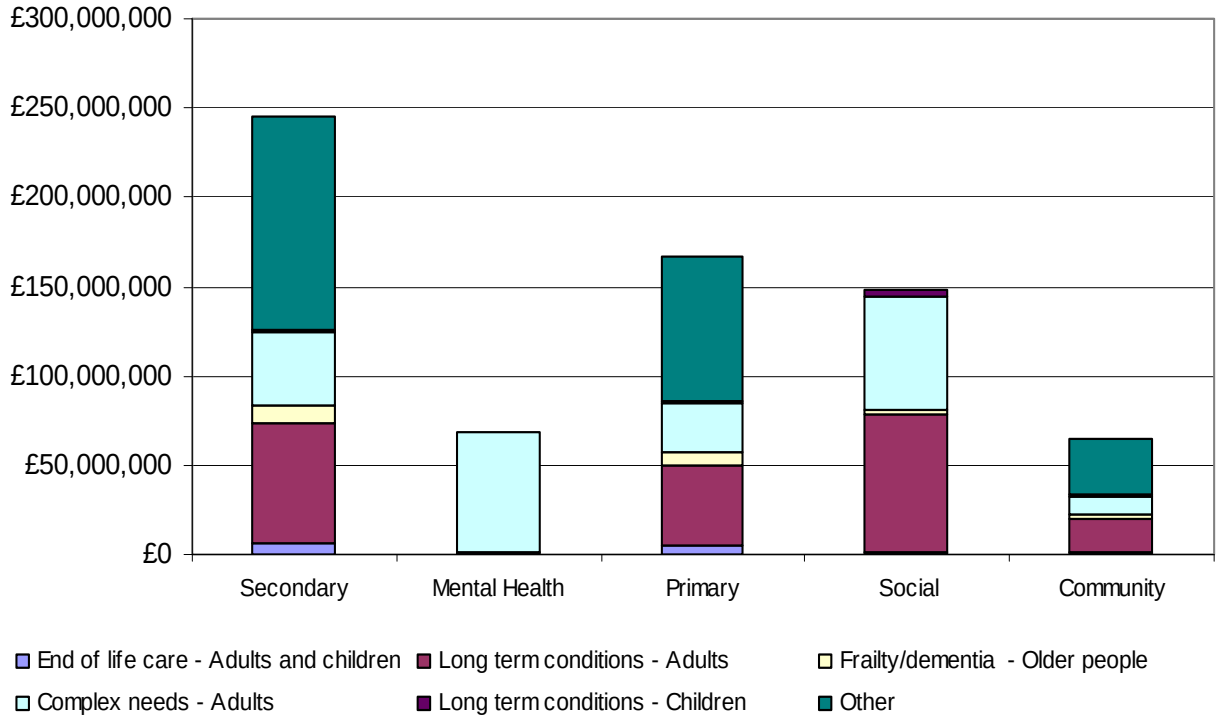



Figure 4: Cost of care by sub-group and setting[1]

4.2.7 To summarise, from this population analysis we can see the following:

- The five sub-groups identified as the highest priority in the Strategic Outline Case make up 18% of the population but 67% of the cost.
- Adults with Long-Term Needs and Adults with Complex Lives account for the largest proportions of health and social care spend, including 44% of secondary care spend.
- The city population as a whole is forecast to increase by 7.3% over the next five years, but the increase will be higher for children (13.8%)

[1] Note that social care costs in the chart only cover costs for the five priority sub-groups.

## 5.0 Care Models

5.0.1 The phase two analysis of the population has enabled commissioners to prioritise and focus resource on those population groups most at risk of escalating need (and costs), those population groups where it is anticipated that the greatest level of shift can be achieved in terms of moving spend and activity from hospital based to community based services. The five priority groups are:

- Adults with Long Term Conditions
- Adults with Complex Needs
- Frail Older Adults and Adults with Dementia
- Children with Long Term Conditions
- Care at the End of Life
- Early Years*

*Please note Manchester's work on the Early Years New Delivery Model is the sixth priority within the Programme. We are in the process of bringing together the Early Years new delivery model programme and the Living Longer Living Better programme into a coherent single programme. However, for the purposes of this document we have focused on the first five priority groups.

5.0.2 Now that we have a deeper understanding of the nature of the target population groups, we have been able to more effectively develop innovative care models that will enable us to more effectively deliver coordinated out of hospital care. The care models set out the strategic priorities for delivering new models of care for each of the target population groups to enable us to achieve the Living Longer Living Better programme goals and aims.

**Illustrative case study: Frail Older Adults and Adults with Dementia**

I am 70 years old and until very recently lived with my husband of 49 years. Unfortunately he passed away last year suddenly after a heart attack. I found it quite difficult to adapt as I have never been on my own.

I was so pleased when my GP rang me to check I was doing ok. I was able to confide in him that I had not realised I had to reset all my husband's direct debits. I had not paid a single bill since he died. I had been receiving lots of cut off notices and repossession notices but I just couldn't face any of it. I felt like it was the end. He quickly arranged for the Multi-Agency Neighbourhood Team attached to the GP practice to visit me. The Social Worker was great. She put a stop on the repossession of my home, got the gas and electric back on and arranged a monthly payment system to clear my debts. I felt so much better that, the GP felt I didn't need to go on to anti-depressants.

The Social Worker and Nurse felt I was getting very low and frail. They asked me some questions and agreed if I got out and about and regained some strength it would help me to feel stronger. I joined something called the Grand Day Out at Wythenshawe Forum each Wednesday. At first I was very nervous but the volunteers there were so kind and introduced me to everyone. I now go bowling on a Tuesday and have joined swimming on a Friday as well. A group of us all meet to shop once a week and have our hair done on a Saturday. I have friends now and that does make life a lot less lonely and a lot less frightening. I felt stronger after just a few weeks.

The nurse that I could have a free flu injection so I went along to the Practice Nurse and she arranged it all for me. My blood pressure and blood sugars were high when the GP checked me over on at a regular check up. The nurse discussed with me a new diet; she weighed me regularly and sorted out my medication. Once it had settled down I just rang up through my community alarm system to give in my blood sugar and blood pressure readings each day. If it is too high or low then they contact the Community Nurse who visits and adapts my medication. The nurse has been fantastic; it took all the fear out of being told I was diabetic.

One day I felt really dizzy and sick. I wasn't sure if it was flu or something to worry about. My daughter was visiting and she wanted to call an ambulance. I refused but I pressed the Community Alarm button. I explained how I felt and they called the GP. He came round an hour later and checked me over. My daughter was really relieved but impressed also that the process to support me worked well. I was feeling very tired and weak. The GP felt I needed a chest x-ray – this was arranged at the local primary care hub. The results indicated I had a very severe chest infection and needed IV antibiotics. I was really worried, as I didn't want to go into hospital. But I shouldn't have worried, as this was arranged at home with the District Nurses visiting and a link through Community Alarm if I was concerned at all. My daughter stayed with me for a few days but I felt much better staying at home and recovered well.

I feel I can manage now

5.0.3 Commissioner leads from the City Wide Leadership Group have led a collaborative design process with voluntary and community groups, leading technical and clinical experts and patient groups to define the care model components and the expected outcomes for each of the five care models. Reference Group members both clinical and non clinical have been a valuable resource and instrumental in providing guidance, and expert advice as the models have progressed.

5.0.4 Each care model has a defined set of expected outcomes, a description of what will be different for Manchester residents, along with the expected system standards and measures for success. Within these high level priorities, we have also identified elements within the care models which we believe to be 'big ticket' items – those interventions which are most likely to make the biggest impact.

5.0.5 The care models have the following key themes running through them:

- Mental health – mental health and wellbeing cuts across the population groups, and the shift to earlier intervention and diagnosis
- Economic growth – enabling more people to manage their health condition effectively in work
- Technology – ensuring we consider the long term shift in delivery models towards new technology innovations, driving both efficiency and effectiveness
- Workforce – developing our workforce so that we have the right balance of generalist and specialist skills – across traditional boundaries – to deliver the new care models in a way that empowers and inspires our collective workforce

5.0.6 These are however still at an early design stage – we now need to give potential providers the freedom and flexibility to innovate to meet the requirements as laid out in the care models, to ensure for example that the latest technological innovations are being factored into self care and care at home. As we move into implementation, we will prioritise the big ticket items that will deliver a shift into out of hospital services at a scale and speed that will enable us to achieve the Programme's aims and outcomes.

5.0.7 A summary of each care model for our priority population groups is laid on out on the following pages and illustrated in the table below:

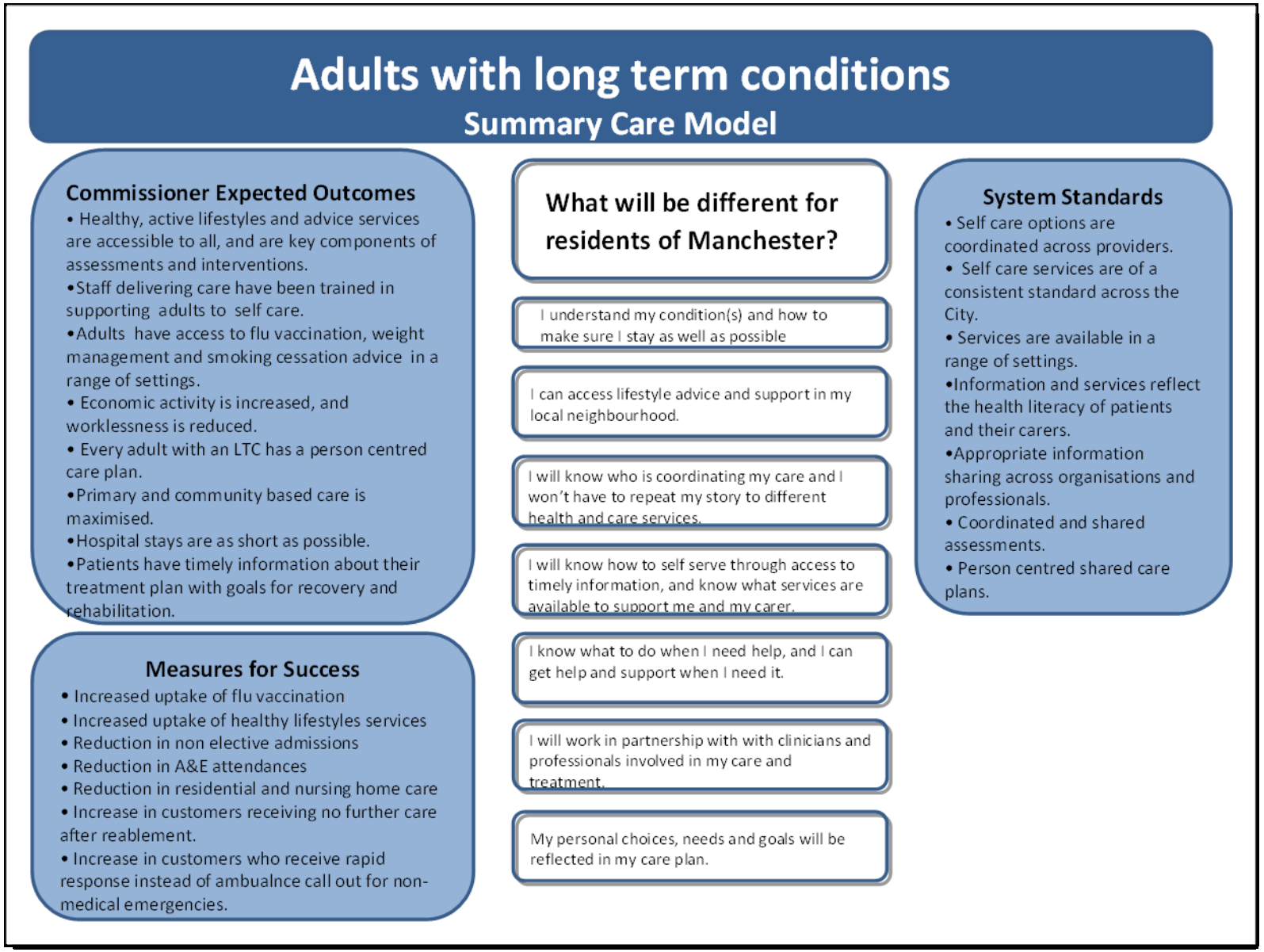
| Population Group | Care Model Components | Big Ticket Interventions |
|---|---|---|
| **Adults with Long Term Conditions** | • Prevent exacerbations and minimise the need for acute episodes of care.<br>• Ensure a timely appropriate response to exacerbation of a condition/s when they do occur.<br>• Promote self management as an approach with clinical and professional staff.<br>• Empower patients to manage their LTC(s) and know what to do if they become unwell.<br>• Support people to work in partnership with clinicians and professions involved in their care and treatment. | • Self management, training staff to support self care approaches.<br>• Coordinated management of multiple long term conditions.<br>• Community based shared care plans for very high, high and moderate need patients.<br>• GPs and specialists working in partnership. |
| **Adults with Complex Needs** | • Create a single point of access system for those with complex needs, which does not rely on people keeping appointments.<br>• Develop a multi agency primary care system, building on the existing Urban Village model.<br>• Extend the role of A & E to include for example, assertive outreach and housing. | • Single point of access which does not rely on an appointment system.<br>• Extending role of A&E |
| **Children with Long Term Conditions** | • Maximise the opportunities for children to self care and self manage their conditions.<br>• Build on the existing arrangements with Statement of Educational Needs<br>• Need to strengthen links with Education, for example, opportunities via PHSE as a potential vehicle for general healthier lifestyle education at school.<br>• Recognising the needs of teenagers are very different to that of younger children, for example in their ability to self care.<br>• Improving the transition between children's and adults' services.<br>• Further work required on children who have a mental health condition, physical disability or who have a learning disability. | • Every child with an LTC has an agreed care plan that is shared by all agencies<br>• Self care and self management<br>• Transition<br>• Maximising opportunities for ambulatory care |

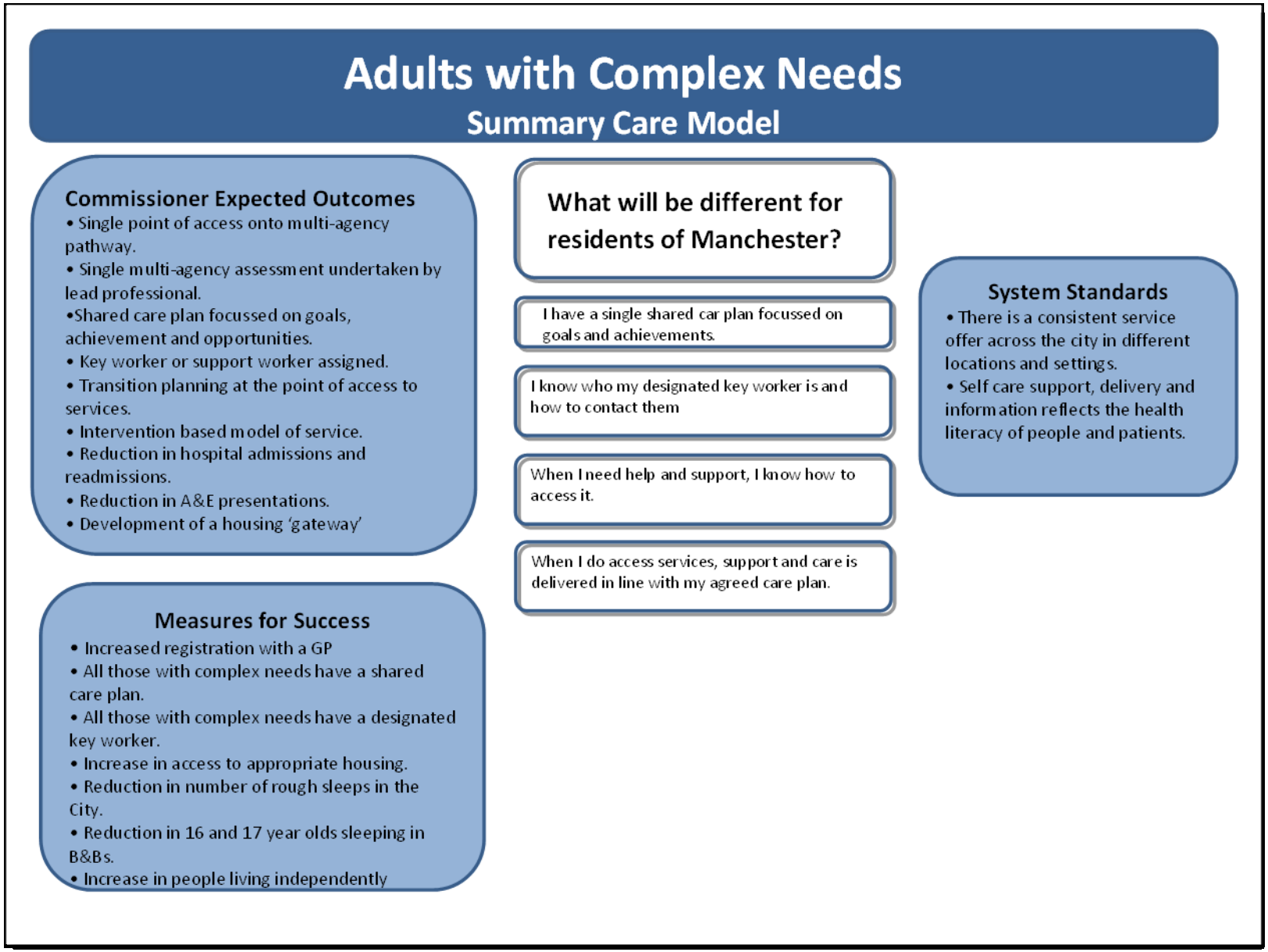
| | | |
|---|---|---|
| **Frail Older Adults and Adults with Dementia** | • Embed anticipatory and shared care planning for frail older adults utilising community and neighbourhood assets and support.<br>• Integrate services and integrate information around supporting people to remain healthy, safe and well at home.<br>• Develop and implement a "frailty assessment" tool with a view to developing frailty registers in primary care.<br>• Early identification of people with dementia.<br>• Improved access to primary care services outside of current core hours. | • Delivery of safe care at home.<br>• One care plan.<br>• Early identification of people with dementia<br>• Frailty assessment tool |
| **Care at the End of Life** | • Deliver integrated health and social care services (as listed for other care models) to meet individual needs.<br>• Early identification and effective communication of entry to the end of life phase.<br>• Provide hospice type models of care<br>• One care plan that the person carer/parent and professionals jointly own, understand and can coherently deliver upon 24/7/365 with the flexibility to change the plan when needed. | • Hospice model of care<br>• Integrated information and delivery of services |

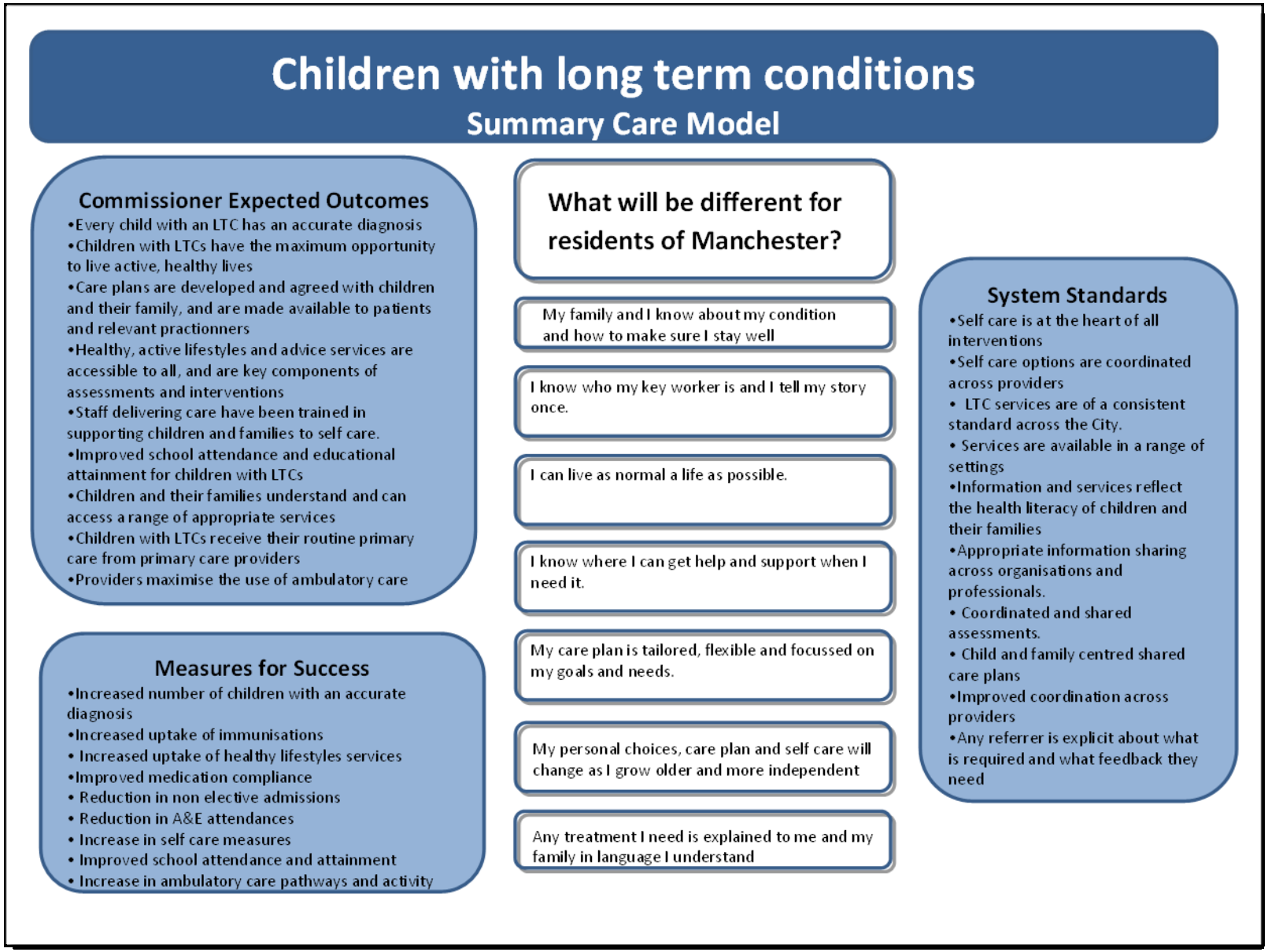
Table 3: Care Models Summary for the Five Priority Population Groups

## 5.1 Measures for Success

5.1.1 Each care model has included a case study that describes what success will look like. The care model outcomes have been a feature of discussion with strategic commissioners in Manchester. The draft outcome measures have been detailed in each care model and the evaluation section in section 7 provides more details. The main emphasis will be on the delivery of coordinated out of hospital care provision, and improved experience.


Adults with long term conditions
Summary Care Model
Commissioner Expected Outcomes
• Healthy, active lifestyles and advice services are accessible to all, and are key components of assessments and interventions.
•Staff delivering care have been trained in supporting adults to self care.
•Adults have access to flu vaccination, weight management and smoking cessation advice in a range of settings.
• Economic activity is increased, and worklessness is reduced.
• Every adult with an LTC has a person centred care plan.
•Primary and community based care is maximised.
•Hospital stays are as short as possible.
•Patients have timely information about their treatment plan with goals for recovery and rehabilitation.
Measures for Success
• Increased uptake of flu vaccination
• Increased uptake of healthy lifestyles services
• Reduction in non elective admissions
• Reduction in A&E attendances
• Reduction in residential and nursing home care
• Increase in customers receiving no further care after reablement.
• Increase in customers who receive rapid response instead of ambualnce call out for non-medical emergencies.
What will be different for residents of Manchester?
I understand my condition(s) and how to make sure I stay as well as possible
I can access lifestyle advice and support in my local neighbourhood.
I will know who is coordinating my care and I won't have to repeat my story to different health and care services.
I will know how to self serve through access to timely information, and know what services are available to support me and my carer.
I know what to do when I need help, and I can get help and support when I need it.
I will work in partnership with with clinicians and professionals involved in my care and treatment.
My personal choices, needs and goals will be reflected in my care plan.
System Standards
• Self care options are coordinated across providers.
• Self care services are of a consistent standard across the City.
• Services are available in a range of settings.
•Information and services reflect the health literacy of patients and their carers.
•Appropriate information sharing across organisations and professionals.
• Coordinated and shared assessments.
• Person centred shared care plans.


Adults with Complex Needs
Summary Care Model
Commissioner Expected Outcomes
• Single point of access onto multi-agency pathway.
• Single multi-agency assessment undertaken by lead professional.
•Shared care plan focussed on goals, achievement and opportunities.
• Key worker or support worker assigned.
• Transition planning at the point of access to services.
• Intervention based model of service.
• Reduction in hospital admissions and readmissions.
• Reduction in A&E presentations.
• Development of a housing 'gateway'
Measures for Success
• Increased registration with a GP
• All those with complex needs have a shared care plan.
• All those with complex needs have a designated key worker.
• Increase in access to appropriate housing.
• Reduction in number of rough sleeps in the City.
• Reduction in 16 and 17 year olds sleeping in B&Bs.
• Increase in people living independently
What will be different for residents of Manchester?
I have a single shared car plan focussed on goals and achievements.
I know who my designated key worker is and how to contact them
When I need help and support, I know how to access it.
When I do access services, support and care is delivered in line with my agreed care plan.
System Standards
• There is a consistent service offer across the city in different locations and settings.
• Self care support, delivery and information reflects the health literacy of people and patients.


Children with long term conditions
Summary Care Model
Commissioner Expected Outcomes
•Every child with an LTC has an accurate diagnosis
•Children with LTCs have the maximum opportunity to live active, healthy lives
•Care plans are developed and agreed with children and their family, and are made available to patients and relevant practionners
•Healthy, active lifestyles and advice services are accessible to all, and are key components of assessments and interventions
•Staff delivering care have been trained in supporting children and families to self care.
•Improved school attendance and educational attainment for children with LTCs
•Children and their families understand and can access a range of appropriate services
•Children with LTCs receive their routine primary care from primary care providers
•Providers maximise the use of ambulatory care
Measures for Success
•Increased number of children with an accurate diagnosis
•Increased uptake of immunisations
• Increased uptake of healthy lifestyles services
•Improved medication compliance
• Reduction in non elective admissions
• Reduction in A&E attendances
• Increase in self care measures
• Improved school attendance and attainment
• Increase in ambulatory care pathways and activity
What will be different for residents of Manchester?
My family and I know about my condition and how to make sure I stay well
I know who my key worker is and I tell my story once.
I can live as normal a life as possible.
I know where I can get help and support when I need it.
My care plan is tailored, flexible and focussed on my goals and needs.
My personal choices, care plan and self care will change as I grow older and more independent
Any treatment I need is explained to me and my family in language I understand
System Standards
•Self care is at the heart of all interventions
•Self care options are coordinated across providers
• LTC services are of a consistent standard across the City.
• Services are available in a range of settings
•Information and services reflect the health literacy of children and their families
•Appropriate information sharing across organisations and professionals.
• Coordinated and shared assessments.
• Child and family centred shared care plans
•Improved coordination across providers
•Any referrer is explicit about what is required and what feedback they need

# Frail older adults and adults with dementia

## Summary Care Model

**Commissioner Expected Outcomes**

- There will be less people admitted to hospital after a fall
- More people will take exercise and eat healthier
- More people will have a medication review annually
- More frail older adults will have immunisations e.g. flu, pneumonia.
- Peoples homes will be planned using long term adaptability
- Kerbs, roadways will be hazard free
- One tool is used to identify frailty across the city and a frailty register will be established
- All frail adults and adults with dementia will have a person centred shared care plan which will be shared across all agencies
- Patients, carers and families will be able to access an online directory of up to date advice, care and support services.

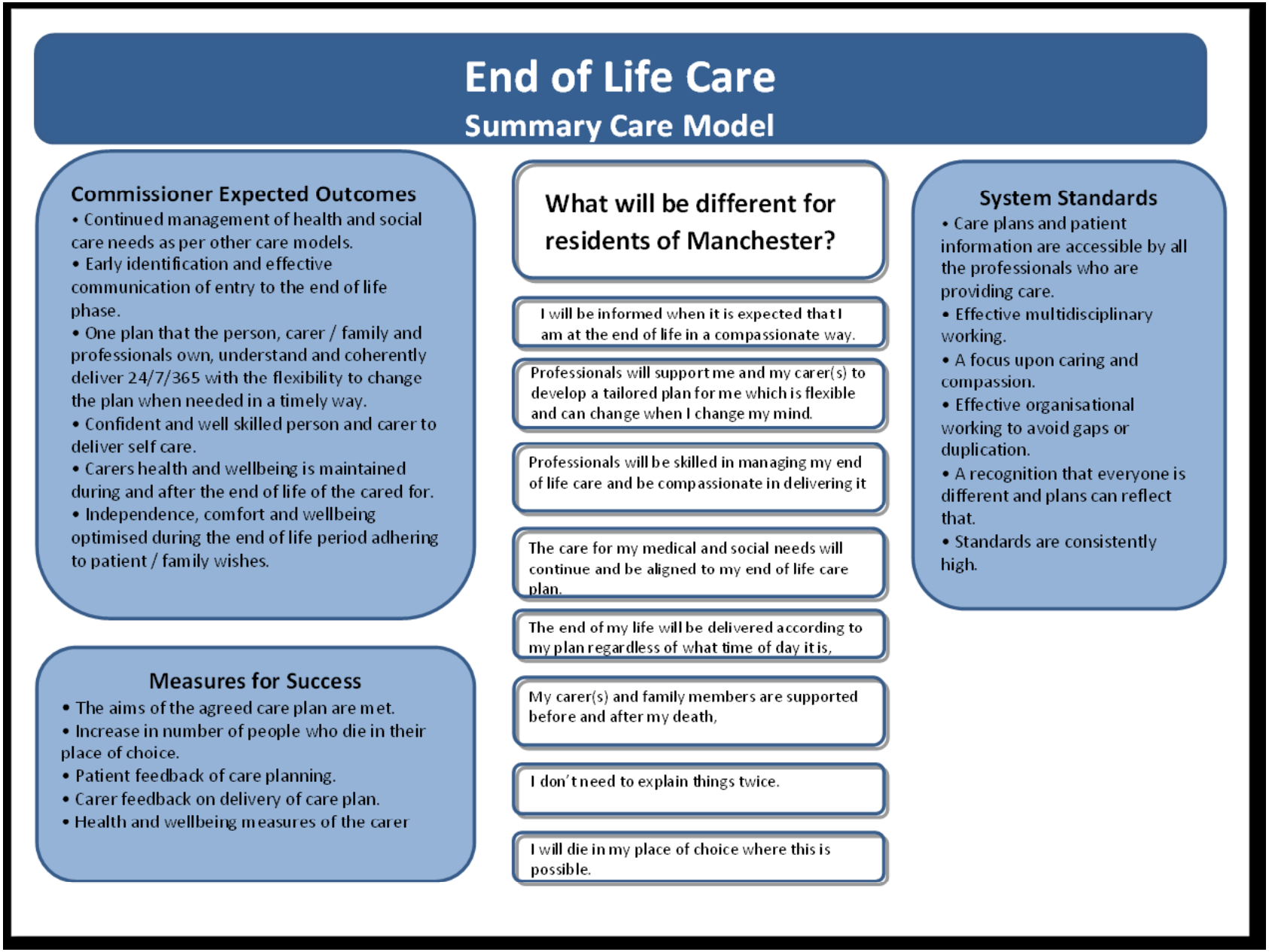
### Measures for Success

- Less unplanned admissions to A/E
- Reduced length of stay in hospitals
- Increased take up of immunisation in over 65yrs
- Increased early diagnosis of diabetes, thyroid deficiency, high blood and cholesterol levels
- Reduced admissions through excessive alcohol intake
- Life expectancy will increase
- More people will be identified earlier as being frail and added to GP registers enabling integrated teams to agree Care plans are in place and delivered.

[redacted]

### System Standards

- A system wide, public health strategy will be in place and inform all providers delivery model
- One shared directory for advice, information, care and support will be available
- Immunisation take up will be 95%
- One tool for identifying frail/ elderly & dementia will be agreed for proactive use
- A joined up approach to access to open public spaces, transport and road maintenance
- Medication reviews will be delivered by pharmacy and issues or concerns fed into GP or neighbourhood teams
- NWAS and Health and Social Care will have a tool to share information and access to care plans for adults
- Anyone admitted to hospital in an unplanned way will be proactively followed up and discharged quickly
- One shared care plan across health and social care system.
- The system responds 24/7
- Consistent care is delivered with reduced handovers
- Lead worker identified for all frail older adults and adults with dementia.


End of Life Care
Summary Care Model
Commissioner Expected Outcomes
• Continued management of health and social care needs as per other care models.
• Early identification and effective communication of entry to the end of life phase.
• One plan that the person, carer / family and professionals own, understand and coherently deliver 24/7/365 with the flexibility to change the plan when needed in a timely way.
• Confident and well skilled person and carer to deliver self care.
• Carers health and wellbeing is maintained during and after the end of life of the cared for.
• Independence, comfort and wellbeing optimised during the end of life period adhering to patient / family wishes.
Measures for Success
• The aims of the agreed care plan are met.
• Increase in number of people who die in their place of choice.
• Patient feedback of care planning.
• Carer feedback on delivery of care plan.
• Health and wellbeing measures of the carer
What will be different for residents of Manchester?
I will be informed when it is expected that I am at the end of life in a compassionate way.
Professionals will support me and my carer(s) to develop a tailored plan for me which is flexible and can change when I change my mind.
Professionals will be skilled in managing my end of life care and be compassionate in delivering it
The care for my medical and social needs will continue and be aligned to my end of life care plan.
The end of my life will be delivered according to my plan regardless of what time of day it is,
My carer(s) and family members are supported before and after my death,
I don't need to explain things twice.
I will die in my place of choice where this is possible.
System Standards
• Care plans and patient information are accessible by all the professionals who are providing care.
• Effective multidisciplinary working.
• A focus upon caring and compassion.
• Effective organisational working to avoid gaps or duplication.
• A recognition that everyone is different and plans can reflect that.
• Standards are consistently high.

## 6.0 Financial Case

6.0.1 As we have developed our understanding of the population groups and focused on the care models for the priority population groups, in parallel we have been building the financial case for change.

6.0.2 Significant progress has been made since the Strategic Outline Case. For the first time we are able to see the costs of existing services split by our population groups, settings of care and commissioner and provider. We understand the financial envelope in which we are working over the coming years. We have modelled at a high level the forecast impact of the new care models, again analysing the impact by population group, commissioner, provider and setting of care. And we have developed a sophisticated modelling tool which will enable us to refine and iterate the financial case as our work on the detailed delivery models develops.

6.0.3 However, the financial case is a complex challenge, reflecting the multiple commissioners and providers operating in the city; the different payment and contracting models; different types of data collected in different ways; and the relatively early stage the new delivery models are at in the development process. The challenges in developing the financial case are compounded by the lack of robust evidence to support the impact of the new care models (reflecting their innovative nature). This has meant securing the right balance of evidence based assumptions where they exist, and using management and professional assumptions where no robust evidence exists.

6.0.4 Key to our approach is that we list all assumptions made; that assumptions are refined as we develop our detailed understanding of the different care models; and as we move into delivery, assumptions are replaced by evidence in Manchester. This reflects our proven Public Service Reform principles in Manchester.

6.0.5 We now have a dynamic modelling tool which enables us to determine financial risk at a macro system level down to individual new delivery models for particular population groups. The financial model that has been developed is flexible so new data and assumptions can be added to improve robustness and increase confidence in the forecast over time. This will mean that the cost benefit analysis can be improved for each stage of the decision making process as the New Delivery Models and data gathering become more developed.

6.0.6 The diagram below illustrates the overall process in developing the financial case, and where we are in the journey.

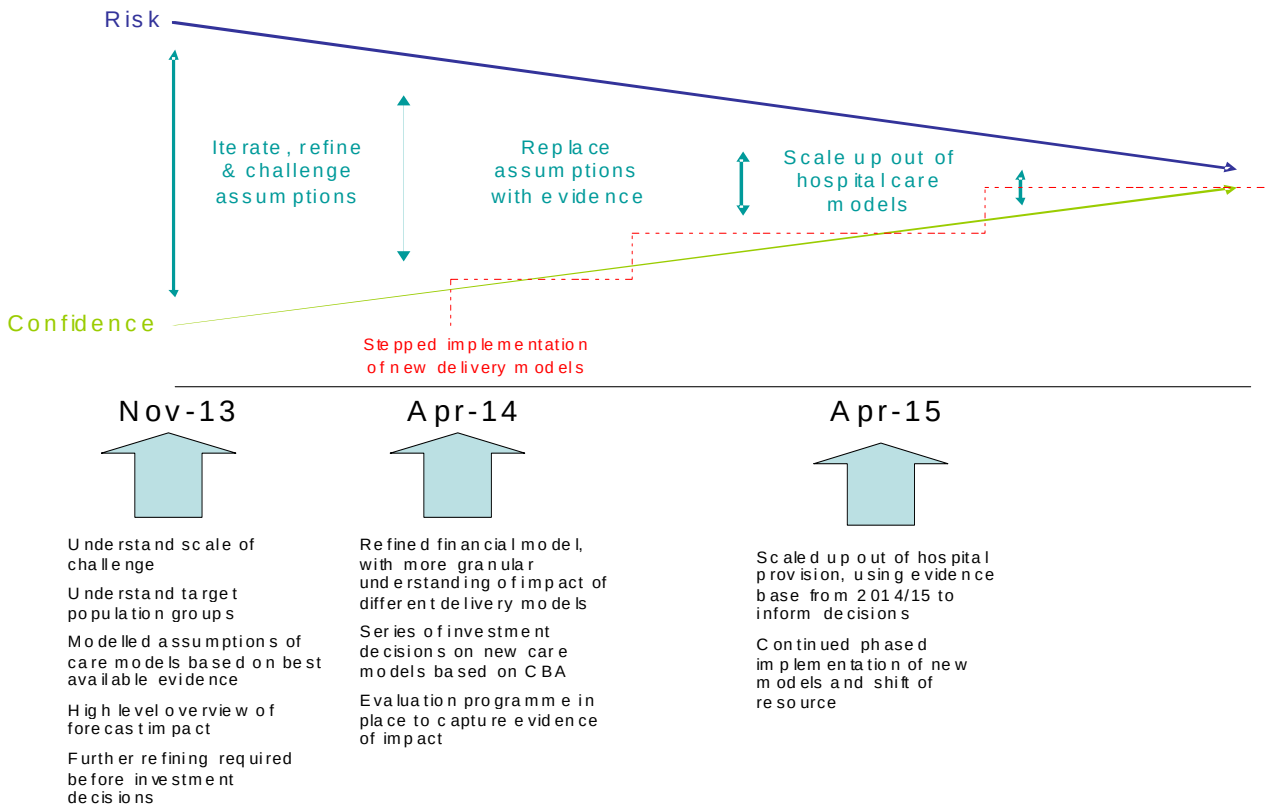



Fig 5: Financial risk management process

6.07 Today there are clear limitations in the available data which underpins the financial case. We have a good understanding of cost and volume of activity by population group within secondary care. However, within community care and primary care the nature of the contracting and funding arrangements means we have had to make high level assumptions on the forecast impact of activity. Similarly within social care it is difficult to make direct comparisons across to health care spend because of the lack of available data.

6.0.8 As we move forward we will refine the data and replace assumptions with evidence from the phased implementation of the new care models.

## 6.1 Approach to Developing the Financial Case

6.1.1 Our approach has been to:

- Build on the analysis undertaken for the Strategic Outline Case
- Map existing activity and costs across providers by population group
- Use existing baseline data collected at a city-wide level in terms of commissioner and provider cost and volume data
- Accessing external data sources where cost data is not available (e.g. making assumptions on the costs of the unregistered GP population).
- Ensuring this joins with Healthier Together modelling and strategic business case requirements.
- Factoring in both costs and prices so that we develop a consistent commissioner and provider view.

- Categorise cost and volume by population group, defining each population group so that each Manchester resident is in one group within the financial model
- Project forward 'do nothing' costs and income over five years
- Model the initial forecast impact of priority care models cost and savings in totality, by setting of care and commissioner/provider
- Reflect and refine – challenging the inputs, outputs and assumptions by finance and care leads across each commissioner and provider in the city.
- Produce new iterations through development of New Delivery Models and Contracting.

6.1.2 In building the finance case, it is important to reinforce that:

- Finance leads from each commissioner and provider have been involved in the production of the model, the development of assumptions and the beginning of the iteration process of key inputs and outputs
- This is the first stage in the modelling process. We need to secure local evidence of impact to replace the modelled assumptions
- Living Longer Living Better is one element of the health and social care growth and reform plans in the city
- The model's insights form an important part of the decision making process but are not the sole criterion and will need to be considered alongside other critical factors including clinical outcomes.

6.1.3 Key aspects of the financial case are outlined below.

## 6.2 Five Year Income Trajectory

### *CCG Income*

6.2.1 From a CCG perspective there is a lot of uncertainty in the financial outlook. Key areas of uncertainty are:

- A potential shift to a new formula for calculating allocations to CCGs which would reduce allocations to the Manchester CCGs.
- The detail of how the CSR shift of resource from health to social care will work.
- Ongoing demand risk relating to provided services
- Longer term values relating to primary care and specialist care budgets.

6.2.2 These factors may impact each CCG differently, but overall CCGs can reasonably expect a growing gap between income and expenditure of just over £40m over the next five years if no actions are taken (see Figure 6 below).

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| **Income (less surplus requirement) £Ks** | 702,373 | 678,439 | 671,215 | 672,336 | 676,728 |
| **Expenditure (before QIPP) £Ks** | 702,373 | 698,476 | 708,246 | 713,907 | 719,535 |

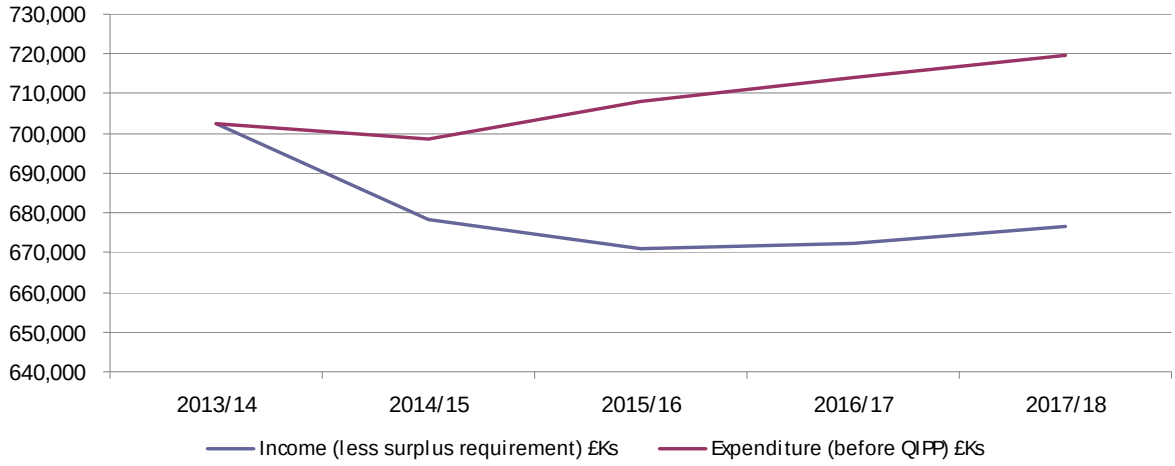



Figure 6: Projected CCG Income and Expenditure if no action is taken

### *Provider Income*

6.2.3 Separate to the CCG pressures, NHS provider organisations have significant pressures of their own - the latest estimates for Healthier Together show a financial gap in 2017/18 for the eight acute providers across Greater Manchester, which (as an illustration) if apportioned by population would result in a £153m shortfall facing Manchester providers. This could rise to as much as £350m if apportioned based on trust income.

### *Manchester City Council Income*

6.2.4 Manchester City Council is planning the likely financial resources that will be available from 2015 to inform proposals to support the delivery of the vision for the city. Alongside this is the need for the Council to maintain and deliver a balanced budget. There will need to be a more radical approach to the way services are delivered to manage funding reductions that the Council will face in 2015/16.

6.2.5 Provisional allocations of government grant funding sets out a loss of core government grant of £51.7m in 2015/16. The reductions required for 2016/17 are not known, but based on CSR totals for local government funding could be a further £16m. It should be stressed this is an early estimate. It does not take into account the unavoidable cost pressures that the council will need to fund. There is a need to plan for the growing number of people with learning disabilities likely to require support and a significant increase in the 0-4 population over the last 10 years as well as inflationary pressures and increases in levy costs.

6.2.6 The Council has not formally agreed any budget reductions or how they will be allocated for 2015/16. The likely scale of the savings required including the funding reductions and unavoidable cost pressures have been identified and applied for illustrative purposes. The purpose of this is to give an indication of how the Council's financial resource envelope for integration could be affected based on the information known so far.

6.2.7 Indications for 2015/16 are that savings of a further £70m (19%) will be required from departmental budgets, after taking account of inflation and demographic pressures and that savings of c£100m are likely to be required over 2015/17. At this stage no assumptions are being made for 2017/18.

6.2.8 Whilst no targets have been set a pro-rata reduction for targeted and specialist services is shown below for illustrative purposes only (in reality the position is likely to be different). This would result in a financial envelope for integration over the next five years as set out in the table below. These projections:

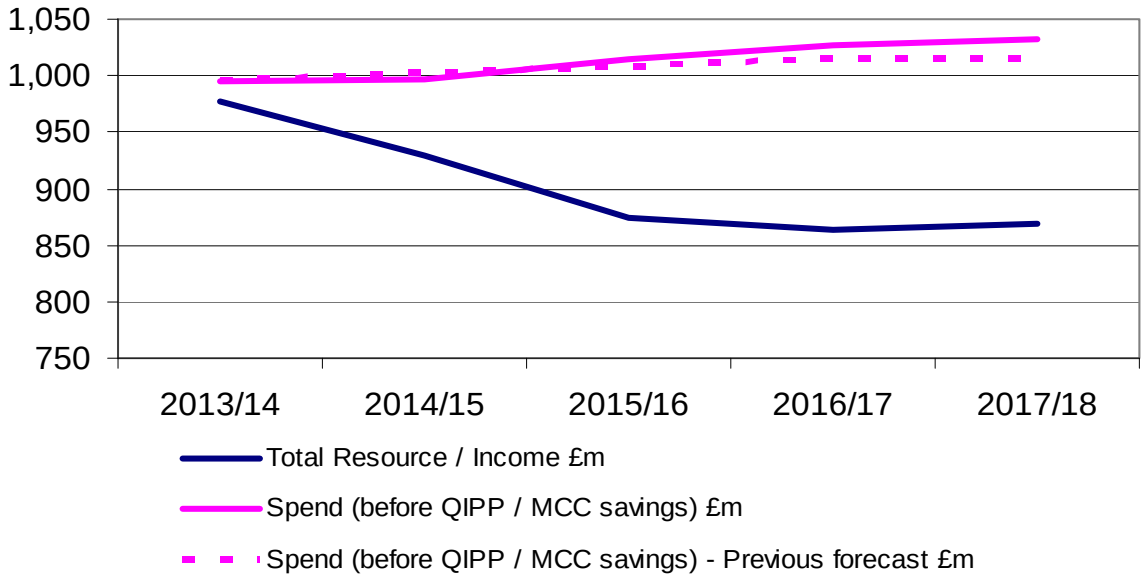
- take into account the existing NHS funding transfer.
- exclude the estimated additional 'new' £18.9m which is being met from 'NHS allocations'. This additional element of the funding transfer is to support integration, support some of the costs associated with the Care Bill (e.g. the move to seven day working for parts of social care) and to support social care services.
- assume the impact of the 2015 Care Bill and response to the Dilnot recommendations due to impact in 2015/16 are to be cost neutral with the costs being met from new burdens funding.

| **Manchester City Council Targeted and Specialist Services** | **2013/14 £m** | **2014/15 £m** | **2015/16 £m** | **2016/17 £m** | **2017/18 £m** |
|---|---|---|---|---|---|
| **Expenditure** (exc. Inflation and demography) | 286.8 | 274.5 | 251.2 | 203.4 | 191.8 |
| Inflation | 1.0 | 2.7 | 2.5 | 2.0 | |
| Demography | 5.0 | 3.6 | 4.2 | 5.1 | |
| **Available resource** | **274.5** | **251.2** | **203.4** | **191.8** | **191.8** |

Table 4: Available resource for Targeted and Specialist Services

## 6.3 Combined CCG and Council Resource

6.3.1 The combined resource for integration across health and Council targeted and specialist services is set out in table and graph below. It indicates a need to reduce costs by £139m by 2015/16 to meet potential funding reductions and meet pressures, and £164m by 2017/18. The dotted line presents the original combined expenditure forecast presented to the Health and Wellbeing Board in September, which has subsequently been updated reflecting the latest estimates.




| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| **Total Resource / Income £m** | 977 | 930 | 875 | 864 | 869 |
| **Spend (before QIPP / MCC savings) £m** | 995 | 998 | 1,014 | 1,027 | 1,032 |
| **Spend (before QIPP / MCC savings) – Previous forecast £m** | 995 | 1,001 | 1,008 | 1,015 | 1,015 |

Figure 7: Combined resource / spending pressure 2013/14 – 2017/18

## 6.4 Forecast Impact of the Care Models

6.4.1 We have used the cost benefit analysis (CBA) model to estimate the potential gross benefit that could be achieved through a reduction in secondary care. This helps us to understand what a feasible, yet stretching level of savings could look like and for this strategic business case we have modelled four scenarios:

- a bottom up approach based on high level, initial assumptions on what the new care models might deliver. These assumptions will be refined as the design of the new models progresses.
- a quartile analysis looking at what could be achieved from reducing non-elective secondary care to the national lower quartile (i.e. the lowest 25% performing CCGs), median and upper quartile (highest 25% performing CCGs) levels for the priority population groups. We have used non-elective admissions data as the basis for setting the quartile target levels except for End of Life care, where we have used place of death metrics. We have also assumed that elective care measures are unaffected. In terms of scale of the challenge, to get to the national average for non-elective admissions would require Manchester achieving a 19% reduction in admissions[2].

[2] These calculations are based on the NHS crude (i.e. actual) rates. Using standardised rates adjusted for demographics would lessen the gap.

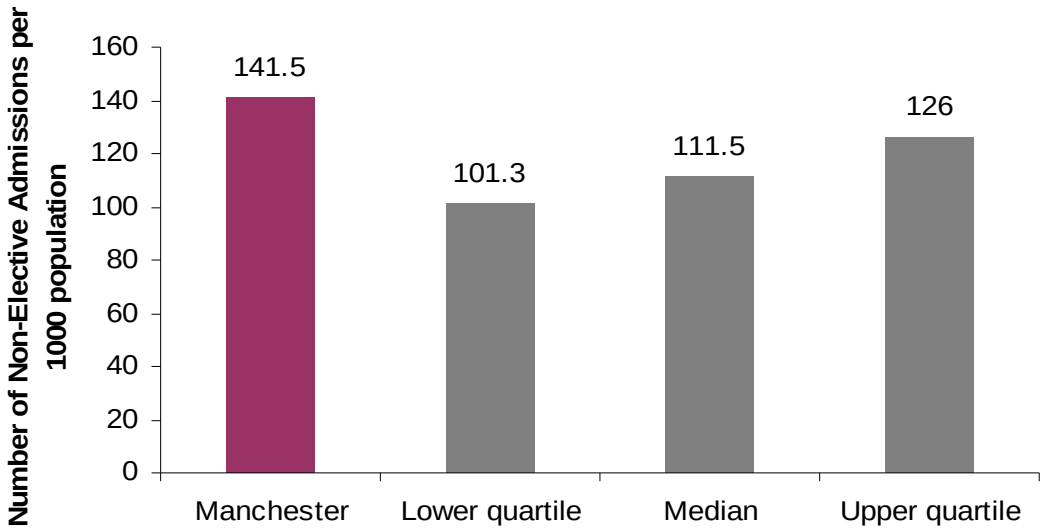



Figure 8: Number of non-elective admissions per 1,000 population (2011/12)
Source: NHS Comparators

6.4.2 Figure 9 illustrates the gross benefit in these four scenarios. Taking the bottom up approach first for the five care models, we estimate that this will deliver c.£10m gross savings on the basis of initial, high level assumptions. This represents 6% of the £164m funding gap and is similar in magnitude to the savings achieved from reaching the national average on non-elective admissions. In other words the bottom up assumptions already include some degree of stretch but they need to be evidenced and refined as the models develop.

6.4.3 However, we can see from the graph that there is potential greater upside available if hospital admissions can be significantly reduced. Moving to the upper quartile on non-elective admissions would deliver gross savings of around £19m for the five priority population groups.

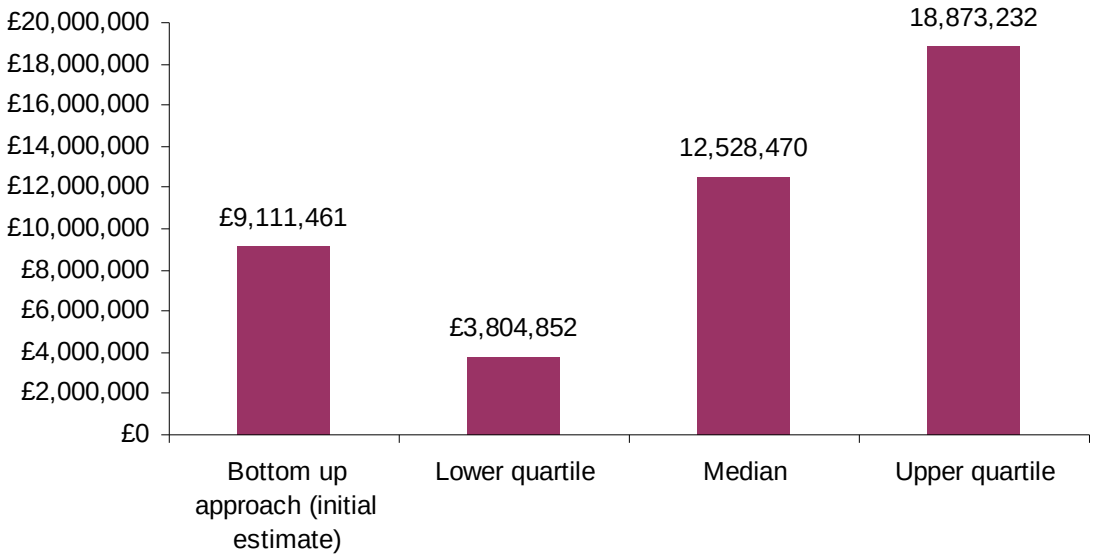


Figure 9: Projected gross savings in secondary care under different scenarios

6.4.4 Reduction in non-elective secondary care admissions is just one example of the forecast cost savings, in addition to for example forecast reductions in residential care placements, length of stay, reduction in readmissions etc. The financial model developed includes these variables, but we have simplified the data for presentation purposes to illustrate the opportunity and challenge going forward.

## 6.5 Recommendations

6.5.1 In summary, our recommendations are to:

- Recognise where we are in the financial analysis and risk management process. We have significantly improved our understanding of the costs and activity of the as is by population group, but need to refine these assumptions – both the inputs and outputs.
- Continue to develop the care models based on the above financial analysis, recognising the positive impacts highlighted above but with the key caveat that we need to challenge ourselves in terms of the ambition we are setting ourselves and the balance of ambitious assumptions vs. robust evidence.
- Support providers in developing innovative new delivery models to meet the care model requirements, ensuring sufficient creative challenge throughout the design process to ensure new models meet commissioner aims.
- Refine and test key elements of the model as more information on the nature of the new delivery models (costs and benefits) are developed over the coming months
- Bring back refined investment proposals to the Health and Wellbeing Board on an iterative basis through to April 2014, making objective investment decisions based on the best available evidence and financial forecasts
- Ensure each organisation within the city is able to use the dynamic modelling tool, training and supporting each organisation effectively
- Overlay this Living Longer Living Better analysis with other reforms and efficiency programmes in the city, so that we have a complete picture of the costs and impacts of different reforms in Manchester.

## 7.0 Implementation

7.0.1 A number of key enabling workstreams were identified in the Blueprint for Living Longer Living Better, including new contracting arrangements, development of new delivery models and provider partnerships, the development of an evaluation framework, our approach to stakeholder engagement and work on core infrastructure elements of estates, workforce and IM&T.

7.0.2 Work is progressing on all of these elements, each of which is critical to successful and sustainable change to the way we deliver health, care and wellbeing services in the city. An outline of progress in each workstream is expanded upon below.

### 7.1 Commissioning, Contracting and Funding

#### *Commissioning*

7.1.1 Since the establishment of the LLLB programme and from experience of the early months of the new NHS structures is has become clear there needs to be some means of ensuring coherence of the commissioning of care for the people of Manchester. For this reason a group 'Strategic Commissioners' has been established which has membership from Manchester City Council, North, Central and South Manchester CCGs and NHS England GM Area Team. The Group have agreed a set of High Level Strategic Commissioners Principles. This group will take a broader remit than LLLB but will have a close focus upon the design and delivery of the LLLB care models.

7.1.2 The development of working arrangements between commissioners and providers within the city has proven to be a key enabler of change and the partnership arrangements established prior to LLLB and developed as part of the programme have accelerated improvement programmes significantly. As described in section 7.2 below, provider organisations have assessed the feasibility of developing priorities in the care models into New Delivery Models 'NDMs'. These will be developed as propositions to commissioners and subject to the relevant decision making processes. Commissioners will assess whether the remaining care models have alternative commissioning options which can be taken forward.

7.1.3 This approach has an inherent tension within it which is managed throughout the governance structure of LLLB, local systems and each statutory organisation. However, this tension is a productive one which alongside the effective partnership arrangements will support progression of the aims of the programme.

#### *Contracting and funding*

7.1.4 In the LLLB Blueprint contracting and funding was identified as a key enabler to support service change. This proposed that new models of contracting and funding should be used to support service change in a sustainable way to achieve system aims.

7.1.5 The Strategic Outline Case developed this view into an options appraisal around contracting and funding. The aims for contracting and funding were defined as:-

- 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 population health and wellbeing.
- To support the process of transition to the new care model from the existing one.

7.1.6 The paper also described a list of principles by which any contracting models should be built upon. A shortlist of contracting options was agreed which would then be applied on a case by case basis when care models are developed.

- Informal network
- Accountable Care Organisation
- Prime Contractor
- Alliance Contract

7.1.7 Commissioners and providers have now commenced the annual contracting process, which gives a good opportunity to progress thinking around new contracting and funding options. However, this will run alongside the process of developing new delivery models which will mean the contracting and funding design will need to develop concurrently with a view to formalising in contracts from April 2014.

7.1.8 CCGs have incorporated a number of proposed actions into their commissioning intentions letters (which city wide commissioners and providers need to be both cogniscent of and align intentions as appropriate). These include:-

- A focus upon LLLB care model delivery as part of the annual programme of work and to develop assumptions for contracted activity.
- A desire to align performance related payments to common outcome measures in all contracts e.g. acute, secondary care and mental health.
- Working towards system wide performance frameworks for population groups.

7.1.9 Central Manchester CCG has signalled its intent to co-commissioners and provider partners to enter into a ‘Pre-Alliance Contract’ from April 2014. This aims to make a meaningful step towards a full Alliance contract in 2015. This aims to move some, but not all, of contract value into an Alliance Contract but leave a significant proportion within an existing bilateral arrangement (see figure 10). The CCG has received agreement to pursue such an approach via

the Central Manchester Clinical Integrated Care Board and is starting the process of more detailed discussions.

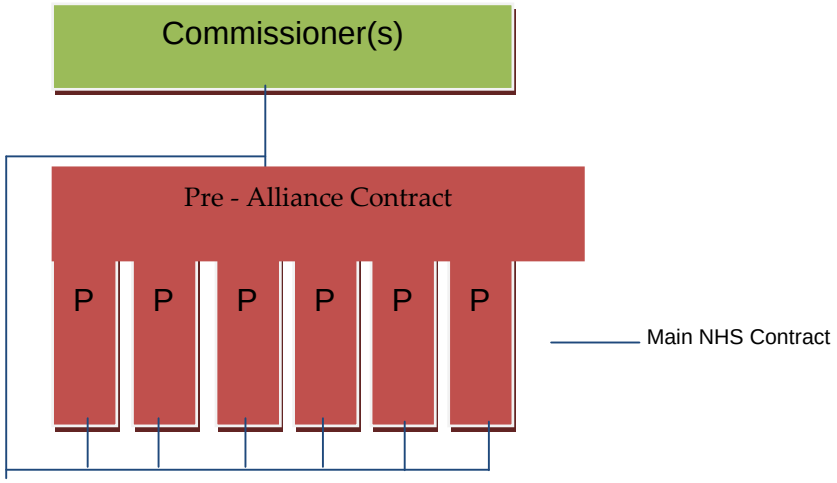



Figure 10: Pre-alliance contracting

7.1.10 There are a number of issues which will make moving to a new contracting model difficult:

- The population groups are difficult to create definitions for in order to quantify cost and activity.
- Patient flows between geographical areas mean that there are no clean boundaries for commissioning or provision.
- North Manchester CCG are not the lead CCG for the Pennine Acute Contract but are part of a collaborative arrangement between the four CCGs which match the Pennine footprint.
- Providers and commissioners have different relevant population groups i.e. registered and/or resident.
- Contracting changes will be complex and may bring financial risk to organisations within the partnership.
- Alliance contracts will require a new kind of relationship between partnerships of providers, who will potentially compete for income and for commissioners who will have differing priorities. The principles stated within the Strategic Outline Case will be developed into new contracts as a reference point for the partnership.

## 7.2 New Delivery Models and Provider Partnerships

7.2.1 The development of new delivery models is a provider partnership response to the commissioners care models. The commissioner care models are a city wide offer with outcomes and impacts which need to be achieved. It is extremely important that providers are given the time and authority to build relationships and to use their knowledge and expertise in model design, turning commissioner intentions into practical delivery.

7.2.2 The following describes the way forward for developing new delivery models which must include more than one organisation and provide a component of care in the community. They must address not only reform but efficiency and performance to achieve the commissioner care models.

### *City Strategic Provider Partnership*

7.2.3 The city wide provider partnership was established in October and meets weekly. Its invited membership is listed below.

| Lead | Organisation |
|---|---|
| **Sara Radcliffe (chair)** | CMFT, city wide leadership team, lead for LLB new delivery models |
| **Joanne Royle** | UHSM, city wide leadership team, lead for LLB estates |
| **Debra Lyon** | PAT, city wide leadership team, lead for LLB workforce |
| **John Harrop** | MHSCT city wide leadership team, lead for LLB evaluation |
| **Diane Eaton** | MCC city wide leadership team, lead for LLB system reform |
| **Dr Vish Mehra** | Central Manchester GP Provider Organisation |
| **Dr Simon Baxter** | South Manchester GP Federation |
| **TBC** | North Manchester GPs |
| **Dave Williams** | Manchester carers Forum |
| **Neil Walbran** | Manchester Health Watch |
| **Lisa Woodworth** | Go To Doc – Out of Hours provider |
| **Mike Wild** | MACC |
| **TBC** | NWAS |
| **Project Support** | Provided from CMFT |

7.2.4 Its aim is to provide an overall steer for the new delivery models and constructive challenge to the system/city in terms of strategic provider development. Local systems will work together to design and deliver the new delivery models in their areas.

7.2.5 The city wide strategic provider partnership will design and propose an overall template of how the design of new delivery models could be implemented . This will include service design, partnership integration, system alignment, engagement (patients, carers, practitioner and the wider community), cost, impact, performance and enabling infrastructure including workforce, information and estates.

7.2.6 In the first instance the three acute/community NHS Trusts will lead in facilitating the coming together of the local providers in an appropriate structure for decision making. This is based upon capacity and does not assume leadership of a new delivery model nor future leadership of the partnership of providers.

7.2.7 For the first phase of work to design new delivery models for April 14 the city wide strategic provider partnership have agreed the following work programme:

| Commissioner Care model | Provider System priority | Big Ticket Areas that could be addressed | Service Foundation for Shift | Design Lead |
|---|---|---|---|---|
| **Adults at the End of Life** | Central, North , | • Hospice model of care<br>• Integrated information and | yes | 3 system |

| | | | | |
|---|---|---|---|---|
| | South | delivery of services | | s |
| **Adults with a long term conditions** | Central, North, South | • Self management, training staff to support self care approaches,<br>• Co ordinate management of multiple long term conditions,<br>• Community based shared care plans for very high, high and moderate needs,<br>• GP and specialists working in partnership | yes | 3 system s |
| **Frail Elderly and/or dementia** | Central, South, North | • Delivery of safe care at home<br>• One care plan<br>• Early identification of people with dementia<br>• Frail assessment tool | yes | 3 system s |
| **People In Crisis** | Central , North | • Single point of access which does not rely on an appointment system<br>• Extending role of AE | yes | Central |
| **Early Years** | Central, North , South | • Sustainability of the model from the scaling up of the three pilots around the city | yes | Central |

### *Local Provider Partnerships, Accountability and Governance to Design New Delivery Models*

7.2.8 Each of the three systems will agree local partnership of providers which will be accountable to their integrated care boards. The membership of these boards will be up to local provider negotiation and based on those providers who will be crucial to the designing future new delivery models.

7.2.9 The initial function will be for providers to design the Living Longer Living Better new delivery models. This will be based on identifying:

- which big tickets will have the biggest impact for phase One (April 14)and potential for implementation
- the current provider map of services that are within the scope of the big ticket Item
- Proposed the new design with partner providers
- Proposed new delivery model and wider system impacts as in the table below

| | |
|---|---|
| **Category (a) services**: play a critical role in delivering the integrated care model – the Big Ticket | • Incorporated within the NDM Agreement<br>• Part of a new contractual base |
| **Category (b) services**: are impacted by the integrated care model or indirectly support it, i.e. likely to experience an increase or reduction in demand | • Not directly included within the NDM Agreement<br>• Services monitored, with financial risk and benefit sharing |
| **Category (c) services**: are unlikely to experience any material impact in the short or medium term | • Services excluded from the NDM and not monitored |

7.2.10 Local decisions will be made in the provider partnership groups and their designs will be fed up to the local integrated care boards for agreement. At this point the new delivery models will be subject to contract models and negotiation so that any plan for implementation with providers can be agreed for April 14. This will be the remit of the local commissioners with their provider organisations.

7.2.11 It is also evident that if we are to achieve a level of success for April-14 we need to realistic and practical. We also need to be able to trust the partnership of providers to lead the work in their systems as they see appropriate. This will mean:

- Building on what we have together, integrating to deliver better outcomes and greater impact
- Ensuring we are making space for creativity
- Ensuring we are looking to enable others to continue or build upon their contribution e.g. carers
- Reducing any duplication that might be happening and ensuring that we are properly performance managing the integrated services as a system, in terms of outcomes and impact - this links to contractual arrangements and agreed measures - reduction in AE, hospital and care home admissions, lengths of stay
- Ensuring that we are clear on what are core services for the integrated new delivery models and which services may not be in the new delivery models but will be impacted in terms of decreasing or rising demand e.g. A&E
- Some services will cross care models and new delivery models.

### *Issues and risks*

7.2.12 There are a number of issues and risks that have already been identified by the city wide strategic provider partnership which need to be mitigated against. In particular these are:

- Contracting process, performance measures and formal accountability need to be clear and its impact understood on provider business models
- The timescales are challenging and the design work needs to be realistically scoped

- Pump priming resources will be needed, if some designs are to implemented for April-14 as there will need to be double running as well as infrastructure costs
- There is an issue about the capacity of smaller organisations to be able to contribute because of capacity and the use of resources to support them

## 7.3 Stakeholder Engagement

7.3.1 Living Longer, Living Better has come along way in a short time. Partner organisations have worked effectively together to identify population groups, develop high level care models and begin the work to specify new service delivery models in the community. Alongside this, across Greater Manchester, the Healthier Together programme has been developing proposals to reconfigure hospital services across the conurbation with a view to beginning a formal consultation in 2014. This formal consultation will explain how hospital service change is reliant on community services and primary care working effectively together to care for people in the community. The aim being that only treatment which requires the clinical expertise or facilities found in hospitals will take place there.

7.3.2 Whilst this may be an easy concept to grasp, the changes to current services will be considerable and must be supported by a programme of communication and stakeholder engagement which is meaningful, timely, honest, open and consistent. What is also clear is that no one person or organisation can be responsible for this. As with the overall development of LLLB, each partner organisation has to play a lead role in ensuring that all their stakeholders are kept up to date with developments and are aware how they can influence the programme.

7.3.3 A stakeholder analysis has been undertaken which has identified the broad range of interested parties and considered how best to engage with them. The principle is to, as far as possible, use existing communication channels and mechanisms to support the work. Development of key messages and timing of communications will be determined centrally but partner organisations will tailor their approaches according to their target audiences and their established relationships. Co-ordination with the Healthier Together programme will be crucial in terms of language, timing and the overall ‘story’.

7.3.4 Up until now, engagement has occurred with those stakeholders who have a direct ‘interest’ in the programme or influence over its delivery. This includes senior managers and clinicians, voluntary and community sector organisations, front line staff delivering services as part of the integrated care pilots, and elected members.

7.3.5 The challenge now is to engage a much wider audience than has so far been engaged, as we move into phased implementation of the programme. From October to December, internal communications will be focused upon to ensure that all staff in partner organisations are aware of the programme and its

ambition. Public communication will begin in earnest at the beginning of 2014 in line with the Healthier Together public engagement and consultation work.

## 7.4 Enablers: Information Management &Technology, Estates and Workforce

### *Information Management and Technology*

7.4.1 Information, Management and Technology (IM&T) encompasses all of the IT equipment, systems and data that we need to underpin our new delivery models. The clear focus for IT is to make the right information, available at the right time to the right person, whether this is to the patient themselves, a clinician or member of staff involved in care delivery.

7.4.2 We continue to make small scale progress with the development of our shared care record and care planning system, supporting our integrated neighbourhood team pilots across the city. There is still extensive work to do to develop our IM&T in a sustainable and scalable way to support the future health and care system.

7.4.3 Building on the as-is analysis prepared for the LLLB strategic outline case, the IM&T leads for the city have started work to map and align existing projects and initiatives with the agreed Care Model priorities. As new delivery models are developed the detailed information and technology requirements will be identified and incorporated into our overall IM&T development strategy.

7.4.4 A number of key themes have already been identified including the need to focus on patient centred information and systems, mobile working, telecare and telehealth solutions, greater informatics capability and a robust infrastructure that enables secure and timely data sharing within agreed information governance arrangements.

7.4.5 Telecare and telehealth solutions are being tested in a range of pilots across the city. Examples include home monitoring for patients with chronic lung disease, and tablet dispensers supporting patients to take medication appropriately. These types of new technologies are important tools for supporting and enabling people to remain and live independently at home. Further work is required as we develop our new delivery models to ensure we fully exploit these technology based opportunities.

### *Estates*

7.4.6 In the estates chapter of the strategic case, our original blue print statement that was set out was ‘to have quality buildings providing multi-agency co-ordinated care to support people to live longer and live better’. The estates domain group was tasked 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. In order to achieve this, the group committed to endeavour to understand our current citywide estate provision and where the gaps are.

7.4.7 The original aim of the group has now been refined further in response to the developing LLLB strategic business case. The Estates domain group will provide a portfolio of health, primary care (GP) and social care facilities across the city. This will include the arrangements for the management of the

facilities, their condition and capacity to provide clinical and administration space.

7.4.8 Early indications as this work progresses is that there is available space in our existing buildings that can be utilised, although in a number of cases the space is available during the out of hours periods and over the weekend. That being the case, currently it appears unlikely that more buildings are required to support the implementation of LLLB. It is more likely that the best and most accessible of our building stock is used differently and more flexibly, for example, providing services at the weekend, and utilising less administration areas for a more mobile workforce.

7.4.9 The estates domain group plans to present back to the three localities (central, north and south) an outline of the estates that are in the best condition and can be utilised differently to support the LLLB programme by November 2013. Originally a 'visual' was presented within the outline case which showed where our collective buildings were. This showed our assets plotted on a map of the city, indicating their locations in relation to Ward and Locality boundaries, and overlaid on a map of main arterial routes throughout the city. In order to place these into neighbourhood contexts we propose to overlay these details onto a layer indicating the position of community hubs/neighbourhood centres, where other public and community sector assets and convenience amenities are located.

### *Workforce*

7.4.10 Workforce redesign will underpin safe and sustainable delivery of the new health and care system. Our workforce, including carers, are the biggest resource asset we have available to us, and are critical to successfully changing the way we support people in the future who have health and care needs.

7.4.11 We will build on existing and successful models that already support independence and wellbeing such as reablement, health trainers and self care approaches.

7.4.12 New ways of working are likely to include the potential for a) alternative care givers b) alternative care settings, and c) alternative care processes. This will mean a move away from a focus on care pathways and dependency on services. Our future care and health system requires a workforce equipped to work in partnership with people, organisations and communities, with equal attention on mental and physical health and wellbeing.

7.4.13 The objectives of the workforce enabling domain are to describe:

- What is currently known about the workforce *currently* delivering elements of the care model (including profile and likely areas for change)
- The current workforce commissioning arrangements
- Plans for a formal baseline assessment of the current workforce

- Interdependencies and implications for strategic workforce planning for implementing the New Delivery Models

7.4.14 This part of the programme is heavily informed by the recent Care Model development and the work plan for Provider development of New Delivery Models. This will give us a basis to further explore, in detail, the implications and planning requirements for our workforce. Service and Education Workforce leaders across our health and care system will now work with partners in Health Education England (North West), stakeholder agencies and with carer and staff representatives on the workforce planning requirements to support implementation of the emerging New Delivery Models from April 2014.

7.4.15 The group will link closely and be supported by the Healthier Together HR and Workforce group which has been established to determine and manage the implications of both the emerging in hospital model and out of hospital or community based care. The group is also contributing to the Greater Manchester baseline mapping exercise for all of the GM 'out of hospital' health and care workforce.

## 7.5 Evaluation

7.5.1 The overall goal for our Living Longer Living Better is to deliver excellent community based coordinated care for Manchester people. In order to ensure that the system delivers the outcome improvements anticipated a clear and supportive performance management framework is needed to both track progress and to encourage the system and culture changes that are needed. Evaluation is crucial if we are to demonstrate the benefits and efficiencies for the programme overall, the respective domains and the identified population groups.

7.5.2 A single approach or framework for measurement and evaluation, shared by commissioners and providers in Manchesters health and wellbeing community, will provide a clear reference point against which strategic decisions in our partnership arrangements can be made.

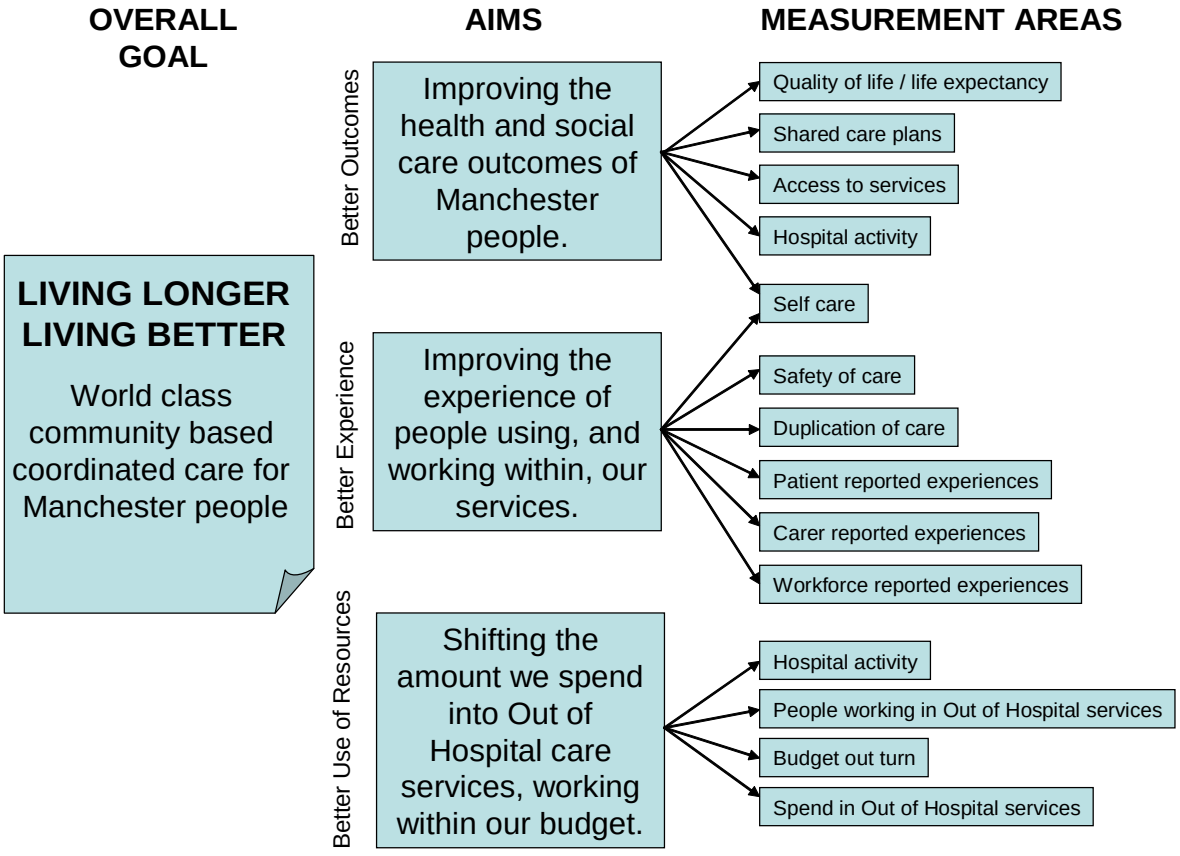
7.5.3 As an initial step, we have identified our three strategic aims for the LLLB programme as:

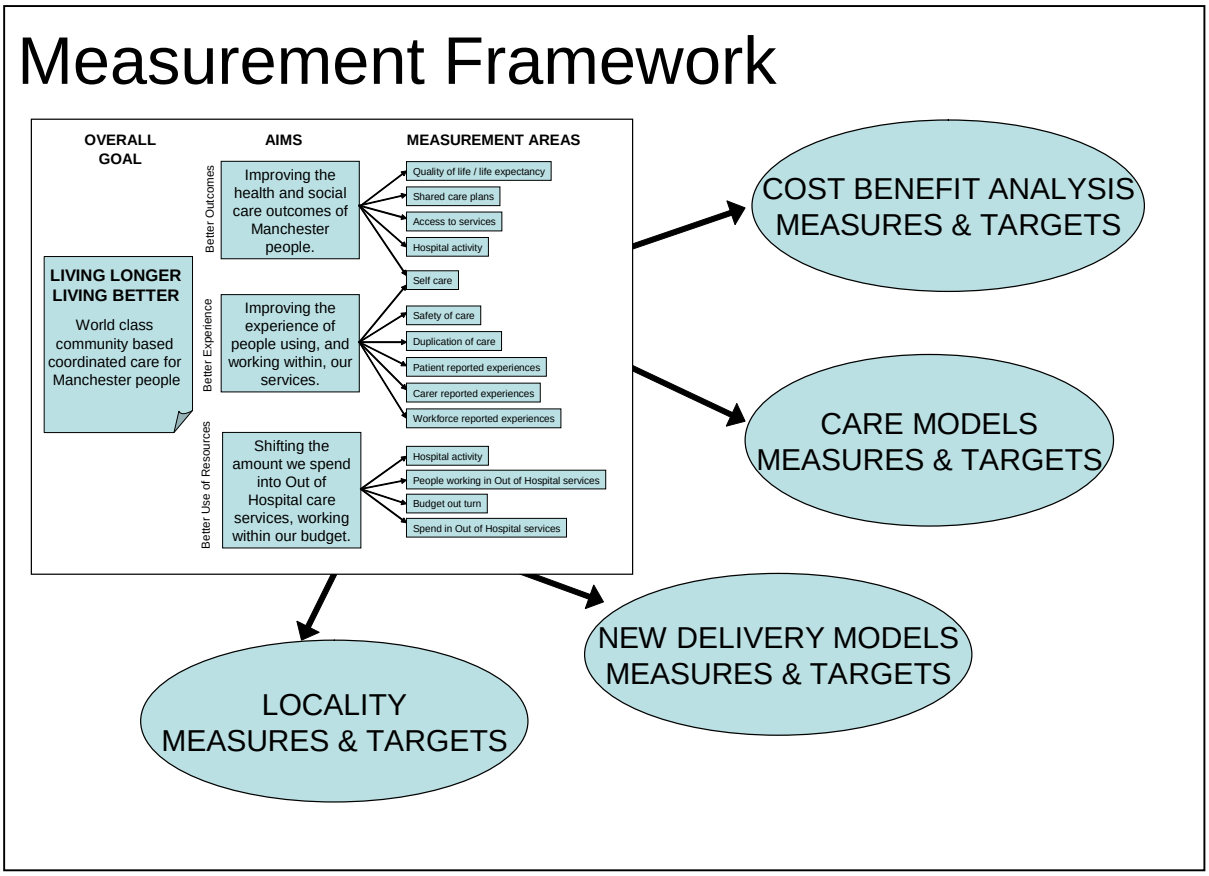
- Improving the health and social care outcomes for Manchester people.
- Improving the experience of people using, and working within, our services.
- Shifting the amount we spend into out of hospital care services, working within our budget.

7.5.4 For each strategic aim the key Measurement themes have been identifed. Work is now underway through a series of workshops to identify specific programme level peformance measures and targets as part of the development of the overall evaluation framework.

7.5.5 To ensure that the measures selected are robust and fit for purpose a set of evaluation criteria has been agreed as follows:

- Is the measure a good indicator towards our overall goal
- Is it robust and reliable
- Is it consistent all the time
- How frequently is it available
- Is it easy to collect and produce
- Does it have face validity
- Is it comparable across England and Internationally.

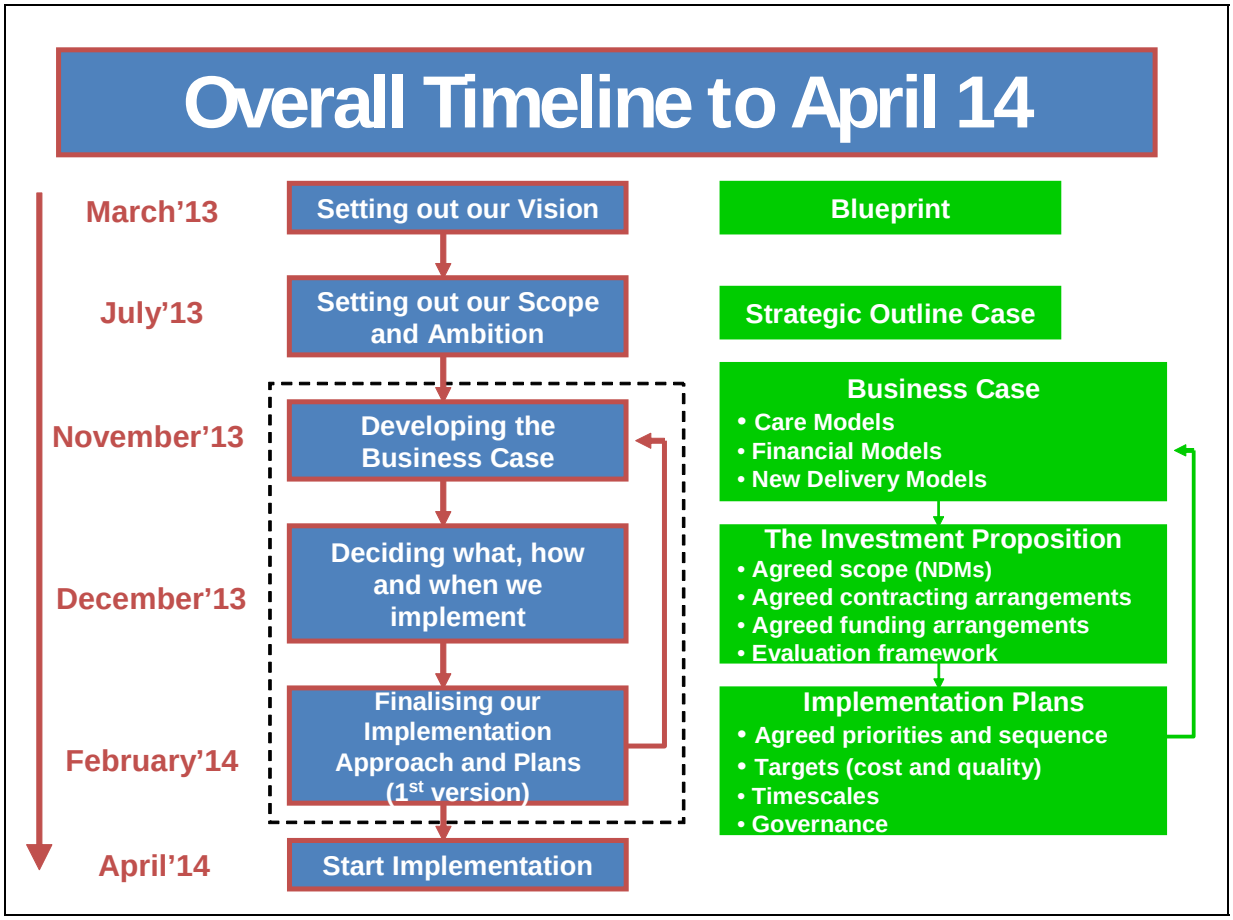





## 7.6 Timeline and Risks

7.6.1 This strategic business case marks an important milestone in the development of the Living Longer Living Better programme. The financial case and evolving cost benefit analysis will inform important decisions that need to be made on how and when we implement our new models of care in Manchester.

7.6.2 Through the next period the city wide team will be further developing the financial model, and preparing the first wave investment propositions to start in April 2014.




7.6.3 The investment propositions we will prepare by December 2013 will detail:-

- The scope and shape of our first new delivery models. How our services and workforce will be configured and developed to deliver the outcomes that the city has agreed as the most important for each priority population group.
- The contracting arrangements which each locality (North, Central and South) will put in place to support delivery of these integrated programmes of care in the city.
- The funding arrangements to support the deployment of resources and services as agreed in the new delivery models.
- The evaluation framework which will underpin successful and sustainable change across the health and care economy.

7.6.4 There are clearly a number of strategic risks with a programme of this size and complexity that need to be visible, understood and addressed through the LLLB partnership arrangements.

| Risk | Mitigation |
|---|---|
| The development of our strategic business case for LLLB sits within the context of three overlapping and dependent programmes of work at a Greater Manchester level – 1) LLLB as part of the GM integrated care programme | The LLLB programme is being developed within the overall GM integrated care programme. The strategic aims and strategies for the three pieces of work are being aligned in Manchester through the |

| | |
|---|---|
| 2) Healthier Together the GM hospital services programme and 3) Primary Care development programme from NHS England. There is a risk that these three programmes are seen and delivered as separate independent pieces of work, and that objectives are not clearly aligned. | agreed priorities of Manchester's Health and Wellbeing Board. The city wide leadership team for LLLB is particularly focussed on ensuring primary care is part of, and not separate to, the new community based care models.<br><br>As we develop and deliver our communication and engagement plans for both our workforce and externally to our patients and customers, we will look to deliver a coherent and consistent message about what the changes mean for them, rather than the artificial boundaries of three interconnected programmes of work. |
| The structure of the health and care economy in Manchester is complex with three Clinical Commissioning Groups, four hospital trusts, the mental health and social care trust and Manchester City Council. There is a risk with this complexity that the LLLB strategy will be implemented and deployed differently through the three locality systems resulting in different service offers across the city. | As we move from strategy to implementation in the LLLB programme it is essential that the overall strategic accountability for delivery of outcomes for Manchester people remains a priority for the Health and Wellbeing Board and its executive groups. The evaluation framework that we put in place for the programme must be developed to ensure that we can measure and evaluate progress across the whole network to ensure improved outcomes are delivered consistently across the city. |
| The financial picture for public services in Manchester over the next few years is extremely challenging with budget reductions across the board for health and care services. There are clearly individual financial risks for each LLLB partner organisation which could create instability for the medium and long term strategic aims of the programme. | It is clear that the increasingly difficult funding picture for public services mean that potential financial uncertainties for all LLLB partner organisations will need to be managed. The cost benefit analysis and ongoing management must continue to be co-owned by providers and commissioners. Funding and contracting arrangements put in place must be sustainable for all institutions and partners involved. |
| The strategic development of Living Longer Living Better in Manchester has been contingent on the relationships between commissioning and provider organisations in the city. The whole scale change of how health and care will be delivered in the future needs collaborative leadership from all sectors of the system. As we move into the implementation phases of this programme, there is a risk that these collaborative relationships will be strained or even break down, which could critically damage realisation of our strategic aims. | Over the next 6 months the governance structures that have been put in place to support delivery of the LLLB programme must be looked at and considered in terms of supporting the next five to ten years of sustainable change in our health and care economy. It must be ensured that we have appropriate forums and groups in place to tackle issues that arise and ensure implementation of our objectives is achieved over the medium and long term. |