Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board –22 January 2014

Subject: Developing Living Longer Living Better Programme: Progress Update

Report of: City Wide Leadership Group

Summary

This paper provides the Health and Wellbeing Board with key updates in the the Living Longer Living Better programme and the iterative process in developing a business case.

It reflects the significantly increased focus on integrated care across each of the city's main health and social care commissioners and providers. It demonstrates the positive progress made in terms of the following:

- Clarity on the goals and metrics used to determine the impact and success of the programme
- Refined population forecasts, including more sophisticated modelling of each population group
- Examples of progress made in the delivery of integrated care, including tangible reductions in non-elective admissions.
- Details on the collaborative approach to new delivery model development, including co-design between patients, voluntary and community groups and hospital trusts
- Examples of detail on the new delivery models for integrated care, highlighting in practical terms how delivery will be different for Manchester's population.
- Updated financial analysis and financial planning, linking the Living Longer Living Better programme to recent developments such as the Better Care Fund.
- Progress in developing alternative contracting arrangements to deliver the new care models, aligning partners around shared outcomes
- More detail on the evaluation approach to the programme
- Feedback from the stakeholder engagement approach to health and social care reforms in the city

This paper also highlights the further work required in developing and refining the business case, recognising that this is one part of substantial long term reforms to the health and social care system in Manchester over the next 5-10 years.

Recommendations

The Board is asked to:

1. Note the positive progress made over the last three months by health and social care partners in the city, particularly the collaborative approach to developing new delivery models
2. Note the implications of the Better Care Fund and the financial analysis undertaken to date, and the important next steps in developing the financial case
3. Approve the proposed stakeholder engagement plan

Board Priority(s) Addressed:

This 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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Contact Officers:

Name: Mike Houghton-Evans
Position: Strategic Director, families, Health and Wellbeing
Telephone: 0161 234 3952
E-mail: m.houghton-evans@manchester.gov.uk

Name: David Regan
Position: Director of Public Health for Manchester
Telephone: 0161 234 3981
E-mail: d.regan@manchester.gov.uk

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.

In November 2013, the Health and Wellbeing Board received a Strategic Business Case, which described in more detail the care models, the population groups and the financial case for change.

Living Longer Living Better: Progress Update

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1. Executive Summary

Manchester is pioneering the delivery of integrated care at scale. Already multi-disciplinary teams, comprising health and social care professionals such as GPs, social workers, practice nurses, and mental health practitioners are operating out of 38 GP practices in local communities across the city, with locations increasing on a month by month basis.

Integrated care teams are helping people discharge more safely and sustainably from hospital, linking to specialist services such as reablement and intermediate care to help people live more independently and reduce the risk of returning to hospital. Similarly, community falls teams, an urgent response service as an alternative to ambulance and A&E attendance, are in place using innovative community alarms and assistive technology to help people stay out of hospital.

The impact of this concerted effort across health and social care partners in the city to deliver more coordinated care across the disparate and complex system is already starting to make an impact. Unexpected visits to hospital ('non-elective admissions') and people staying in hospital for longer than anticipated ('excess bed days') are down in parts of Manchester – bucking the trend for increasing admissions, a real sign of early success of this work.

Despite this good progress, it is still relatively early days in terms of the implementation of integrated care. So looking forward through 2014, there are two big priorities. Firstly, to scale up the good work already in place and to spread it across the city. And secondly, to phase the implementation of innovative delivery models that will further improve the quality of care in local communities in Manchester.

Both these priorities are encapsulated within the Living Longer Living Better programme – Manchester's programme of reform for delivering integrated care. Since the previous Living Longer Living Better submission to the Health and Wellbeing Board in November 2013, considerable effort and resource has been invested by city partners in the development of new delivery models. This includes a strong collaborative approach to developing the new delivery models with local residents, local voluntary and community providers, acute trust providers, GPs and patient representative groups. This paper includes for the first time details of new services and interventions, including for example:

- Development of a consistent frailty tool that can be used to identify and target services effectively
- A single care plan co-produced with patients/residents and shared with all agencies
- 24/7 community based care for those with more intensive support needs, such as people with long term conditions or frail older adults
- Generalist and specialist community based teams able to provide patients / residents with the support they need in or closer to home

- Delivery of safe care at home, which for people at the end of life is encapsulated within the 'hospice at home' concept

More work is required to refine these proposals, stress test them and establish the detailed practical requirements as we move to implementation in 2014/15.

To support the scale up of existing delivery and implement new models, the Better Care Fund has been established by the Department of Health to support Health and Wellbeing Boards fund integrated care proposals, linked to key priorities such as reducing admissions to residential care homes, delayed transfers of care, avoidable emergency admissions and better patient / service user experience.

Manchester is ahead of the curve in terms of developing its proposals and submission to the Better Care Fund – work done over the last 18 months on the Living Longer Living Better programme firmly meets the requirements of the Fund. More intensive detailed financial analysis and modelling is now required as we further refine the new delivery models, with further proposals on the specific models to be submitted in March 2014.

Significant work has also been undertaken by health and social care partners in the city on the technical side of making scaled up integrated care a reality, recognising the complexity of today's health and social care system. This includes for example,

- Clarity on the goals and metrics used to determine the impact and success of integrated care
- Refined population forecasts, including more sophisticated modelling of each population group that the new delivery models are targeting
- Progress in developing alternative contracting arrangements to deliver the new care models, aligning partners around shared outcomes and providing a mechanism for shifting resource around the system
- More granular detail on the evaluation approach to the programme so that we can determine where and how the programme has been successful

The other major piece of the jigsaw that has been developed and included within this paper is the stakeholder engagement plan, to explain how health and social care organisations in the city are working to develop services which are consistent, high quality and designed around the needs of Manchester's residents.

Looking at the programme as a whole, significant progress has been made in the last 12 months. We have shifted from theoretical concepts to practical delivery on the ground, with integrated care a reality for some of Manchester's most vulnerable residents. In 2014/15, our challenge now is to both scale up the services already established, and then build on them by implementing new more innovative models of integrated care. This will be phased throughout

2014/15 and beyond as we continue to implement a 5-10 year programme of radical reform to Manchester's health and social care system.

2. Introduction and Context

2.1 This paper is the next iteration of the developing business case for integrated care in Manchester, the Living Longer Living Better (LLLB) programme. It is designed to give the Health and Wellbeing Board an update on key developments following the previous submission in November 2013. It reflects the significantly increased focus on integrated care across each of the city's main health and social care commissioners and providers. It demonstrates the positive progress made in terms of the following:

- Clarity on the goals and metrics used to determine the impact and success of the programme
- Refined population forecasts, including more sophisticated modelling of each population group
- Examples of progress made in the delivery of integrated care, including tangible reductions in non-elective admissions.
- Details on the collaborative approach to new delivery model development, including co-design between patients, voluntary and community groups and hospital trusts
- Examples of granular detail on the new delivery models for integrated care, highlighting in practical terms how delivery will be different for Manchester's population.
- Updated financial analysis and financial planning, linking the Living Longer Living Better programme to recent developments such as the Better Care Fund.
- Progress in developing alternative contracting arrangements to deliver the new care models, aligning partners around shared outcomes
- More granular detail on the evaluation approach to the programme
- Details on the stakeholder engagement approach to health and social care reforms in the city

This paper also highlights the further work required in developing and refining the the LLLB programme, recognising that this is one part of substantial long term reforms to the health and social care system in Manchester over the next 5-10 years.

Development of the integrated care business case in Manchester

2.2 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.

2.3 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.

2.4 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.

2.5 The Strategic Business Case presented to the HWB in November 2013 detailed for the first time a deeper understanding of the population groups, the care models, the high level financial case for change and the practical steps required to change the system, including for example different contracting models.

2.6 This paper is therefore written within the context of an ongoing development of integrated care in Manchester. Because of the scale and complexity of the system, the models of care and the financials, there is not one single business case, but a continually evolving programme of reform.

Wider health and social care reforms in Manchester

2.7 LLLB has been developed alongside a number of other major programmes of work aimed at transforming health, social care and well-being services in the city. These include:

- *Primary Care strategy* – Plans produced by NHS England describing a new vision for primary care with improved access and a greater range of services available through primary care organisations. In Central Manchester, these new ways of working are being piloted under the Primary Care Demonstrator programme.

- *Mental Health Improvement Programme* – A fundamental redesign of the Mental Health System in the city to address fragmentation of services and to ensure that service users receive a coordinated set of services based around their health and social care needs. Alongside this, there is a redesign of Mental Health and Wellbeing services underway. Both these pieces of work are currently undergoing a period of public engagement due to end at the beginning of February 2014.

- *MacMillan Cancer Improvement Partnership* – Funded by MacMillan, this programme aims to improve identification and management of Cancer within GP practices and community services. It is also focusing on care pathways for lung and breast cancer to see how these can be refined and improved to provider better outcomes and patient experience.

- *North Manchester General Hospital site* – North Manchester Clinical Commissioning Group and Pennine Acute Trust are beginning to plan the development of the North Manchester General Hospital site alongside

Manchester City Council and Manchester Mental Health and Social Care Trust. The vision is to retain key hospital services whilst developing the site to become a 'hub' for health, wellbeing and social care services.

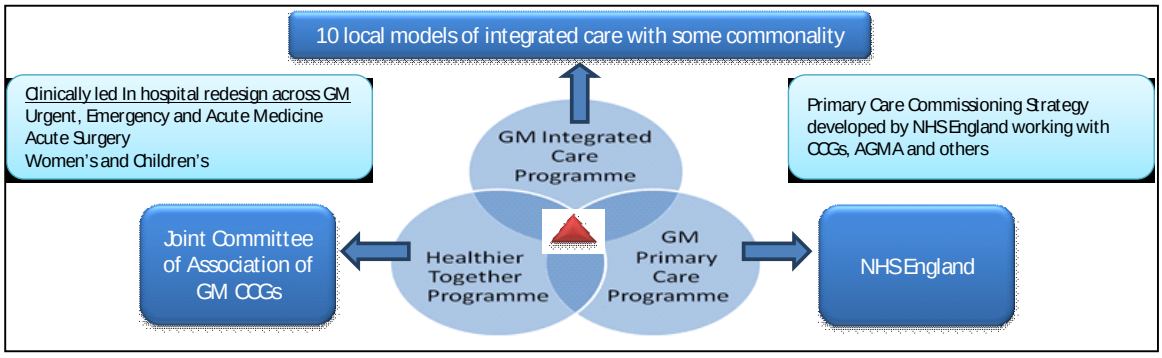
- *Reducing social isolation grants programme* – Funded by the Manchester CCGs and administered by Manchester Alliance for Community Care, this grants programme invites applications from local voluntary sector agencies to bid for monies to develop programmes of work to address social isolation and loneliness in older people – a key contributor to poor health outcomes.

- *Healthy lifestyles service redesign* – A piece of work, led by Public Health Manchester, looking at redesigning the healthy lifestyle services currently available in the city.

2.8 This broad and complex range of programmes, along with other smaller scale service redesigns, show the vast amount of work underway in the city to address the challenges facing Manchester, including consistently poor health outcomes, inconsistent services, increases in demand and budgetary pressures.

Health and Social Care Reforms in Greater Manchester

2.9 The development of the 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

2.10 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

2.11 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.

2.12 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. For example, in Chorlton, Whalley Range and Fallowfield, access to primary care has been extended to 8pm. A city wide reference group for primary care development will ensure learning and best practice are shared across the localities.

Healthier Together

2.13 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.

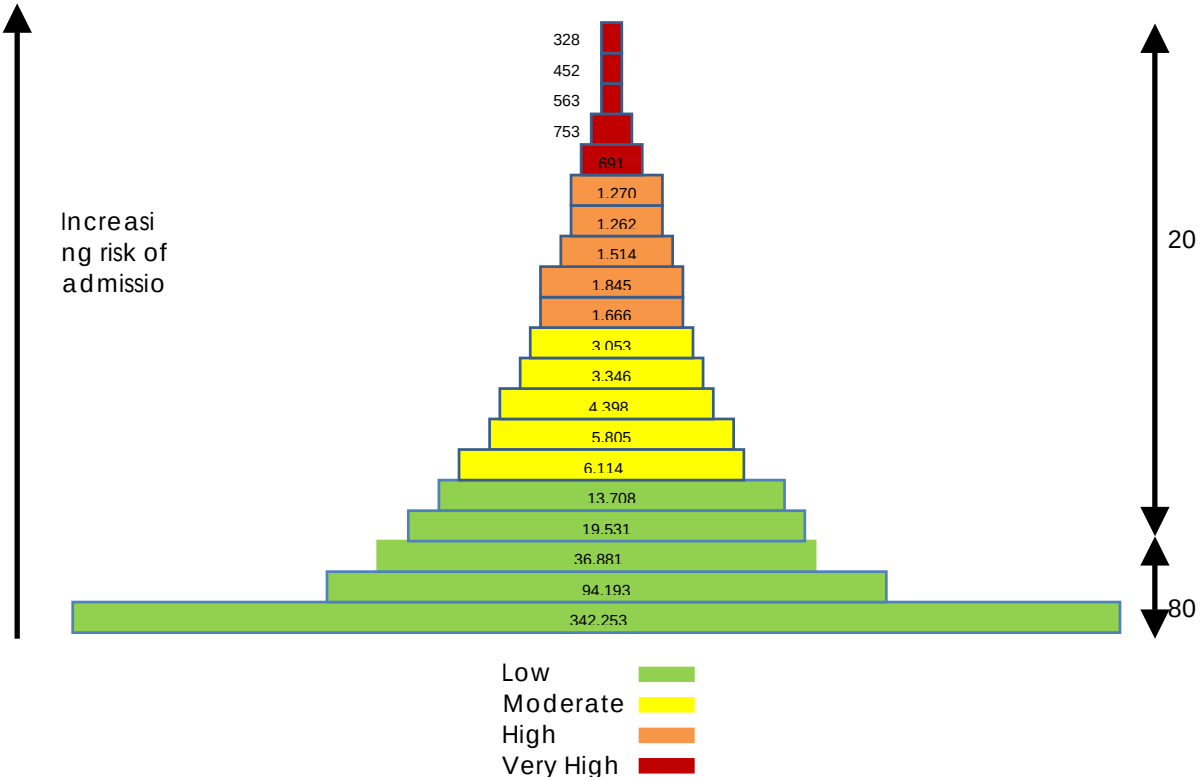
2.14 Progress is being made in designing models of care that meet best practice clinical standards, and in understanding current clinical interdependencies within hospital sites that will inform the reconfiguration and influence the provision of services carried out in the Primary Care and Integrated 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.

2.15 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.

3. Overview of the Population Groups

3.1 For the Living Longer Living Better programme 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 more independently. Over the last 12 months we have built up our understanding of the health and social care needs of Manchester's population in a number of phases:

3.2 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). This highlighted the considerable impact of a relatively small proportion of the population, illustrated below:



3.3 In phase two, we 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. As a result, the city's commissioners and acute trust providers agreed to prioritise work on new integrated care models on the following population groups, illustrated in the table overleaf:

	Sub-group name	High Level Definition	Priority groups
1	**End of life care - Adults and children**	1. Age: 0+ 2. On Palliative care register	✓
2	**Long term conditions - Adults**	1. Age: 19 years + 2. On one or more of the LTC register	✓
3	**Frailty / dementia - older people**	1. Age: 65 years + 2. Secondary care activity including: - Dementia - Broken bones in the upper body - Falls	✓
4	**Complex needs - Adults**	1. Age: 19 years + 2. Presents two or more of: - Drug abuse - Alcohol abuse - Mental health - Homeless	✓
5	**Long-term conditions - Children**	1. Age: 18 years + 2. On one or more of the LTC register Note: may not capture learning disability / physical disability	✓
6	**Carers - Adults and children**	N/A for current modelling purposes	
7	**Good health - older people**	1. Age: 65 years + 2. Included in no other group	
8	**Early years (0-4)**	1. Age: 0-4 years 2. Included in no other group	
8b	**Maternity**	1. Women who have given birth 2. Women who have received antenatal services	
9	**Good health - children**	1. Age: 5-18 years 2. Included in no other group	
10	**Staff - Adults**	N/A for current modelling purposes	
11	**Good health - Adults**	1. Age: 19-64 years 2. Included in no other group	

3.4 In phase three, we are now refining the definition, cost and volume data for the city's priority population groups through a sophisticated modelling tool and dedicated analytical resource to target our integrated care models as effectively as possible. The latest analysis has refined the priority population groups as below.

	Previous Cohort Size		New Cohort Size	
Priority Population Group	**Full population 2012/13**	**% of total population**	**Full population 2012/13**	**% of total population**
End of life care - Adults and children	1,469	0.26%	1,715	0.30%
Long term conditions - Adults	73,315	12.8%	93,388	16.3%
Frailty/dementia - Older people	3,324	0.6%	5,015	0.9%
Complex needs - Adults	26,897	4.7%	1,484 / 4,809	0.26% / 0.84%
Long term conditions – Children	427	0.1%	6,657	1.2%

3.5 The changes made to the population groups are based on the following:

- *End Of Life Care (Adults and Children)* **–** North CCG values increased to match the average proportion of South and Central on an End of Life pathway.

- *Long Term Conditions (Adults)* – Numbers inflated to incorporate estimated Asthma disease register.

- *Frail older adults and people with dementia* – Numbers inflated to incorporate those older people previously ascribed to 'complex needs' cohort

- *Adults with Complex Needs* - Numbers now exclude older people with dementia or frailty *and* a (unidentified) mental health issue. Numbers now exclude those adults with only a mental health issue. Two figures are presented, a) Lower figure presented includes people who fit two of the three categories: admission for alcohol abuse; admission for drug abuse; homeless; b) Higher figure presented also includes people who possess a (unidentified) mental health issue *and* fit one of the three categories above.

- *Long Term Conditions (Children)* – Numbers inflated to incorporate estimated Asthma disease register.

3.6 Work is ongoing in terms of refining the cost and volume data across commissioners and providers for each of these population groups.

4. Programme Aims and Success Measures

Why Measurement and Evaluation are Important to the Programme

4.1 Measurement and evaluation are vital but often neglected elements of delivering large scale, system wide change in the area of health and social care. Simply stated, it is important that, over time, the LLB programme can demonstrate and provide evidence of its success in delivering its ambitions in terms of helping people to live longer and better lives through the mechanisms provided by the development of the Care Models and New Delivery Models, whilst operating within an increasingly constrained financial envelope.

4.2 A recent review by the King's Fund of key lessons and markers of success for co-ordinated care for people with complex chronic conditions highlighted a chronic lack of attention to demonstrating and measuring outcomes. None of the case study programmes reviewed by the King's Fund had actively developed robust methods to demonstrate impacts from the outset.[1] Ensuring that a robust and properly mainstreamed measurement and evaluation framework is in place will therefore put Manchester at a forefront of best practice as far as this aspect of integrated care is concerned.

4.3 Our thinking regarding the development of a measurement and evaluation framework has also been influenced by the best international evidence, notably the US Agency for Healthcare Research and Quality's (AHRQ) Care Co-ordination Measures Atlas.[2] This sets out an approach to identifying relevant care coordination measures based on specifying the mechanisms through which care coordination will be achieved, mapping these mechanisms to specific care co-ordination activities or approaches, and considering the perspective(s) of interest, e.g. patients/families, health care professionals or organisations.

4.4 The different elements of measurement and evaluation are being addressed separately with the first providing the assurance that changes have resulted in rapid and sustainable change and the latter being a more reflective process that takes account of organisational relationships and system wide changes.

Proposed Measurement Framework

4.5 We have started work on the development of a comprehensive measurement framework for the LLLB programme. The aim is not to develop a top-down, mandated set of performance indicators and targets that each of the New Delivery Models (NDMs) must comply with but rather a framework through

[1] Goodwin N, Sonola L, Thiel V, Kodner D. *Co-ordinated care for people with complex chronic conditions: Key lessons and markers of success.* London: The King's Fund, 2013.

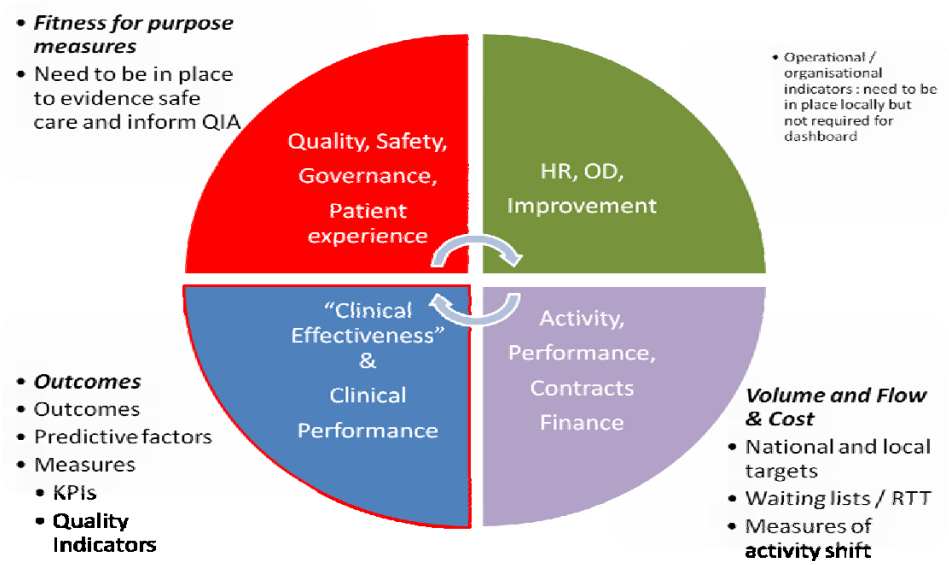
[2] Agency for Healthcare Research and Quality. *Care Coordination Measures Atlas.* U.S. Department of Health and Human Services, December 2010. Available at: http://www.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/index.html

which the NDMs can demonstrate how the metrics they agree locally contribute to the high level aspirations of the LLLB programme as a whole.

4.6 In order to capture the breadth of impact that the LLLB programme is seeking to achieve, it is important that the measurement framework looks at performance across a range of different dimensions and does not simply look at changes in the volume and cost of services delivered within hospital and out of hospital settings. By doing this, the framework will help partners to assess whether the LLLB programme is having the desired effects - and avoiding negative effects - in respect of:

- Quality, safety and patient/user experience
- Cost, volume and flow of services
- Outcomes, clinical effectiveness/performance
- System wide operational efficiency including organisational and human resource effectiveness.

4.7 The diagram below provides a visual illustration of this approach.



4.8 All four 'quadrants' of the above diagram are equally important and need to be considered independently of each other as far as the development of appropriate metrics is concerned. Measuring changes in the organisational and human resource aspects of LLLB programme is particularly complex and is likely to require a different approach from that taken with the other three dimensions of the measurement framework. It is difficult to measure these facets of the work through simple performance metrics without resorting to the use of crude proxy measures and we will look to the broader evaluation work to help us address this issue.

4.9 The first stage of the work has focused on agreeing the high level aspirations of the LLLB programme and on identifying a small number of metrics that can be used to track progress against these aspirations. The following table lists

the high level aspirations as agreed by the LLLB Reference Group on 26th November 2013 and shows how these map to the different segments/domains of the overall measurement framework as described above. This is a way of testing that there is appropriate balance in terms of how the impact of the LLLB programme on the high level aspirations will be assessed.

Aspiration	Domain
Add years and quality to life	Outcomes
	Outcomes
Help people to live more independently	Outcomes
Improve health and social care outcomes in early years (0-4 years)	Outcomes
	Outcomes
Reduce cost & volume of care in hospital	Volume, flow and cost
Increase spend and volume of out of hospital services	Volume, flow and cost
Improve experience of patients/carers at end of life	Quality, safety and patient experience
Improve patient/carer experience of health and social care services	Quality, safety and patient experience
Improve satisfaction of workforce with new delivery models	Quality, safety and patient experience

4.10 Annex 1 lists the initial set of (draft) metrics that have the identified as potential indicators of success for each of the high level aspirations of the LLLB programme. For each of the high level aspirations, the table sets out the:

- **Goal** - the high level goal we are seeking to measure
- **Metric** – the indicator we are proposing to use to measure progress against that goal sought
- **Rationale** - how the LLLB programme will contribute towards achieving the goal
- **Scale of ambition** - the progress we would like Manchester to make relative to other parts of England
- **Timeframe** – the period of time over which we would expect this progress to be achieved.

4.11 It must be remembered that a number of projects, now within the programme, have been underway within the CCG areas for some time and this has been taken into account in the setting of baselines and the development of measures within an overall framework for the initial 5 year period of the programme.

4.12 A number of the metrics listed in Appendix 1 are relatively well established. We have had some initial discussions with Dr Seamus McGirr, Director of Clinical Development at the Greater Manchester Commissioning Support Unit (GMCSU), to discuss operationalising the LLLB measurement framework through the collation of routine data and the establishment of routine reporting and analysis processes through the existing AQUA ADASS ‘dashboard’ nor or

other routes. As part of this, consideration will be given to the construction of a more bespoke reporting dashboard to allow the setting of baselines, the development of trajectories and monitoring of progress.

4.13 Each CCG area has developed methods for evaluating the impact of the integrated care work in each locality. The learnings from each will be shared with the other health economies in the city. In Central Manchester for example, early finding regarding self care – a key plank of the programme – may be shared across the city.

5. Overview of the New Delivery Models

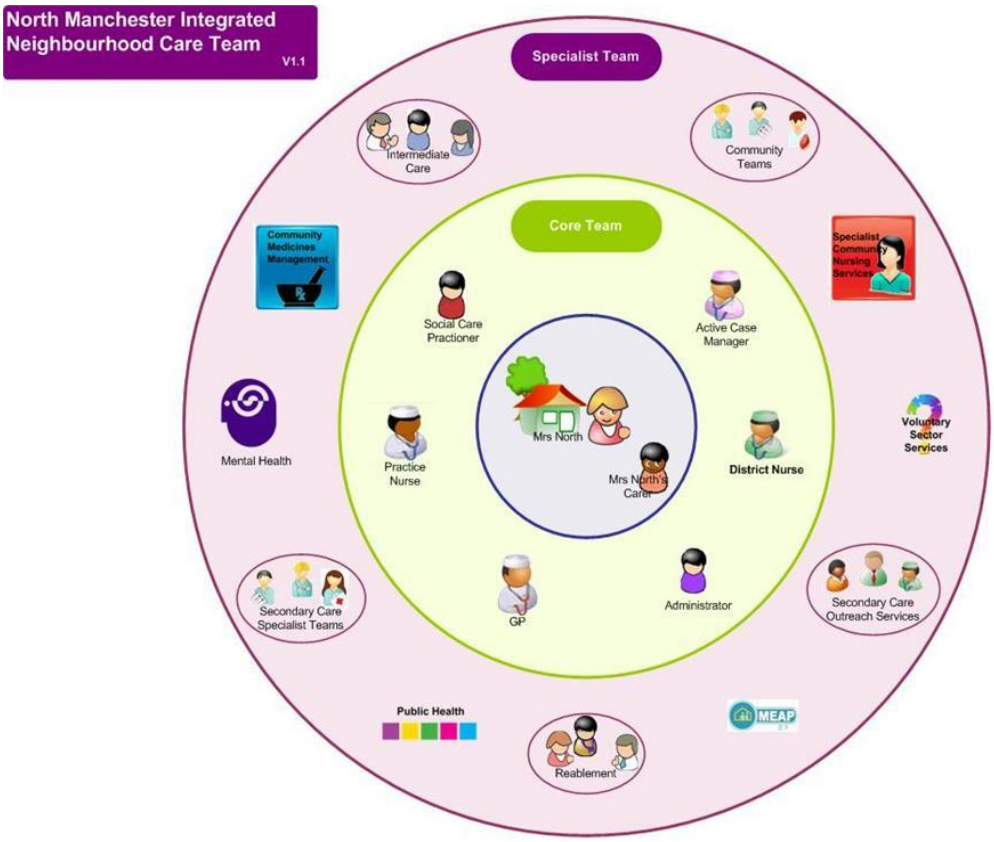
5.1 This section provides an overview of the new integrated care delivery models. It details the significant progress already made in establishing integrated care teams on the ground in Manchester and highlights the early positive impact of more effective coordinated care in reducing non-elective admissions to hospital. It details the approach to further developing and refining the different delivery models for each of Manchester's priority population groups. This section also provides tangible examples of the key differences and features of the new delivery models. Please refer to Annexes 2-4, which provide the latest output of the new delivery model design teams that have been established in North, Central and South Manchester.

Overview of Existing Integrated Care Delivery in Manchester

5.2 Over the last 18 months, commissioners and providers in the city have invested in new delivery models to provide more coordinated, personalised support to residents in the community. This includes the following integrated care delivery:

- Integrated care teams at hospitals, helping people discharge safely and sustainably, linked to reablement and intermediate care support for people in high and very high risk categories
- Multi Disciplinary Teams in the community, operating out of a minimum of 38 GP practices across the city, with core teams comprising of a social worker, GP, practice nurse, community health practitioners, nurse practitioner and health care support worker, including a mental health practitioner in some localities. More GP practices are being added on a monthly basis as the MDTs are rolled out across each locality.
- Integrated community falls teams, an urgent care response as an alternative to hospital attendance, tested with NWAS to divert fallers from admissions using community alarm
- Integrated community specialist teams supporting patients with specific conditions e.g. diabetes and lung conditions as an alternative to hospital attendance
- Integrated community teams working with care homes to support people to die in their home rather than emergency admissions to hospital
- Improved service specification for urgent care in hospital – more consistent, safer quality of care
- Reablement teams – providing step up and step down support to reduce readmissions and hospital length of stay
- A single care plan shared between health and social care (Graphnet) starting to be rolled out for high risk groups using integrated teams
- Using our shared estate differently – co-located teams across the city delivering community care
- Joint workforce development with health for integrated care teams

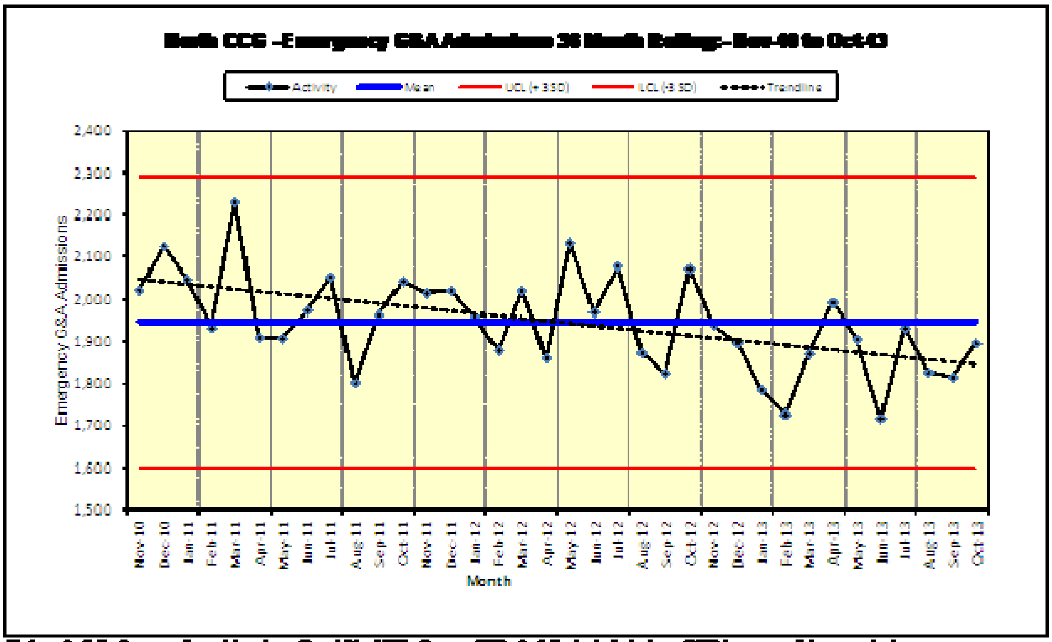
The following diagram illustrates the practical nature of integrated care teams in place, using North Manchester as an example.



Early Impact of Integrated Working Across Health and Social Care

5.3 Whilst it is early days in terms of measuring the impact of the measures outlined in 5.2 above, when taken together with more coordinated efforts to discharge patients safely from hospital, and join health and social care teams in hospital and community settings, early signs are positive across the city. Using North Manchester as an example of the progress being made, North Manchester CCG acute trust activity has fallen in a number of key areas against planned (broadly based on last year's outturn) activity levels as at month 7. The CCG's performance included:

- A&E attendances 4.5% below plan
- Total non-elective admissions 10.1% below plan
- Total elective admissions 5.1% below plan



[illegible]

Quarterly Comparison	Period 1	Period 2	Period 3	Period 4
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

12 Month Period	Variance	% Variance
[illegible]	-	-
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

5.4 Although the activity now seen through the North Manchester Treatment Centre (a new model of ambulatory emergency care) accounts for a significant proportion of the reduction in non-elective admissions, activity has fallen at all sites.

5.5 North Manchester is also seeing the impact of improvements in ensuring timely discharge for patients, helped by an integrated health and social care discharge team under single management at North Manchester General Hospital. This is highlighted by reductions in excess bed days (days over and above what would be expected for each type of admission):

- Non elective excess bed days 30% below plan
- Elective excess bed days 31.1% below plan

5.6 In central and south Manchester, again progress has been positive in terms of the impact of the multi-disciplinary teams, however the results are not yet able to be disaggregated from the macro-level system demands in for example, non-elective admissions. However, it is anticipated that as the integrated care work is scaled up, a similar pattern is expected, if all other factors remain constant.

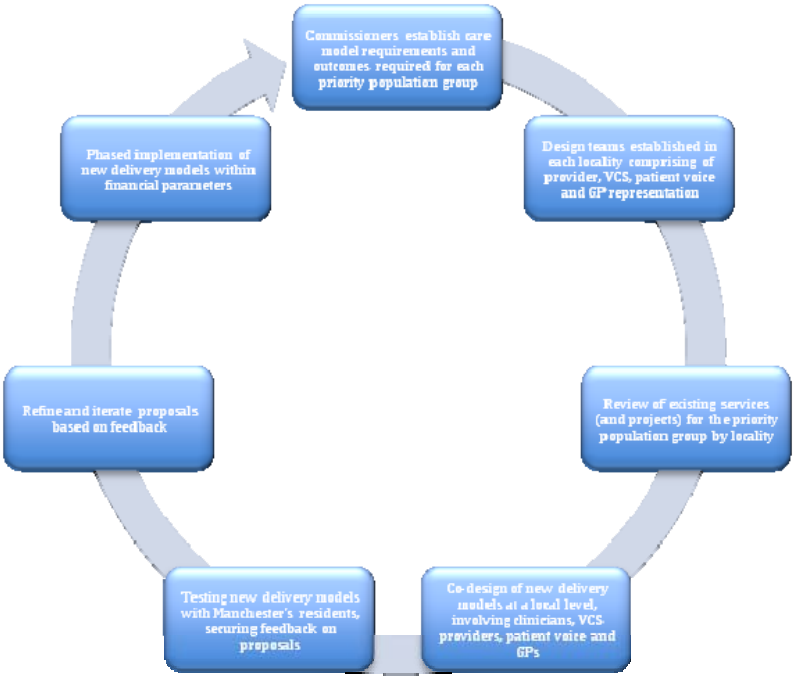
5.7 In developing integrated care in Manchester, there is therefore two key priorities:

- To scale up and spread the existing integrated care models operating in Manchester (described in 5.2), covering for example all GP practices, through 2014 and beyond, capturing the evidence of what works.

- To implement innovative new delivery models currently in the design phase (described below and in the annexes) on a phased basis from 2014/15 onwards. Please refer to section 6.

Approach to Developing Innovative New Delivery Models

5.8 We are taking a collaborative approach for developing new integrated care delivery models in Manchester, summarised in the diagram below.



Collaboration in New Delivery Model Design

Across each locality in Manchester, a strong collaborative approach has been adopted to maximise the input and engagement of voluntary and community sector providers, acute trust providers, clinicians, GPs, patient representative groups, ambulance, out of hours providers, and subject matter experts and academics. In South Manchester for example, 70 representatives from across these organisations have been involved in the design groups, including Parkinson's UK, Age Concern, Alzheimer's Society, Manchester Carers Forum, and the Indian Senior Citizens Centre.

5.9 This approach is underpinned by the following principles:

- Partners have agreed that new delivery models for the city's priority population groups will be developed first, recognising the current health and social care outcomes and costs to the system of these population groups.
- Detailed delivery model design must be service provider led, involving acute trusts, mental health providers, VCS organisations and patient representative groups.

- Whilst the city has three separate CCGs covering North, Central and South Manchester, the city requires consistency in terms of the safety and quality of care and health and social care outcomes. Residents expect the same quality of care regardless of their postcode or the point of care.
- Whilst the outcomes required across the city must be consistent, delivery models can only be developed locally to reflect the local health and social care economy, the provider base and the specific needs of local residents.
- Delivery mechanisms and particular emphasis within the new delivery models will therefore be different across the city, reflecting local resident needs and the specific characteristics of local delivery requirements.
- As a result, the phasing of the implementation of the new delivery models will differ across the city.

Principal care model components and 'big ticket' interventions for integrated care

Population Group	Care Model Components	Big Ticket Interventions
Adults with Long Term Conditions	• Prevent exacerbations and minimise the need for acute episodes of care. • Ensure a timely appropriate response to exacerbation of a condition/s when they do occur. • Promote self management as an approach with clinical and professional staff. • Empower patients to manage their LTC(s) and know what to do if they become unwell. • 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. Includes building on the Expert Patient Programme, successfully delivering in Manchester. • Coordinated management of multiple long term conditions. • Community based shared care plans for very high, high and moderate need patients. • 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. • Develop a multi agency primary care system, building on the existing Urban Village model. • 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. • Extending role of A&E

Children with Long Term Conditions	• Maximise the opportunities for children to self care and self manage their conditions. • Build on the existing arrangements with Statement of Educational Needs • Need to strengthen links with Education, for example, opportunities via PHSE as a potential vehicle for general healthier lifestyle education at school. • Recognising the needs of teenagers are very different to that of younger children, for example in their ability to self care. • Improving the transition between children's and adults' services. • 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 • Self care and self management • Transition • 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. • Integrate services and integrate information around supporting people to remain healthy, safe and well at home. • Develop and implement a "frailty assessment" tool with a view to developing frailty registers in primary care. • Early identification of people with dementia. • Improved access to primary care services outside of current core hours.	• Delivery of safe care at home. • One care plan. • Early identification of people with dementia • 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. • Early identification and effective communication of entry to the end of life phase. • Provide hospice type models of care • 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 • Integrated information and delivery of services

Key Features of the New Delivery Models

5.10 Annexes 2-4 provide an update from each locality on the development of new integrated care delivery models. Collectively, they provide comprehensive details on the collaborative approach being taken in the city to the development of the new models; details on the practical changes to care in the city, including for example the nature of the new community based care teams; and descriptions of new interventions such as assessment tools to improve the delivery of care in the city.

5.11 As stated above, delivery models in each locality are at different stages of development. Each model is subject to further review and refinement; ratification against the financial envelope and available resources; and detailed implementation planning. Each model is also subject to relevant governance arrangements in each locality.

5.12 Outlined below are practical examples of the key features of the new delivery models, at a high level and then by care model. It is not an exhaustive list and summarises what is at times quite complex local differences and technical details, but is intended to give a feel for the nature of the integrated care models.

Common Features of New Delivery Models

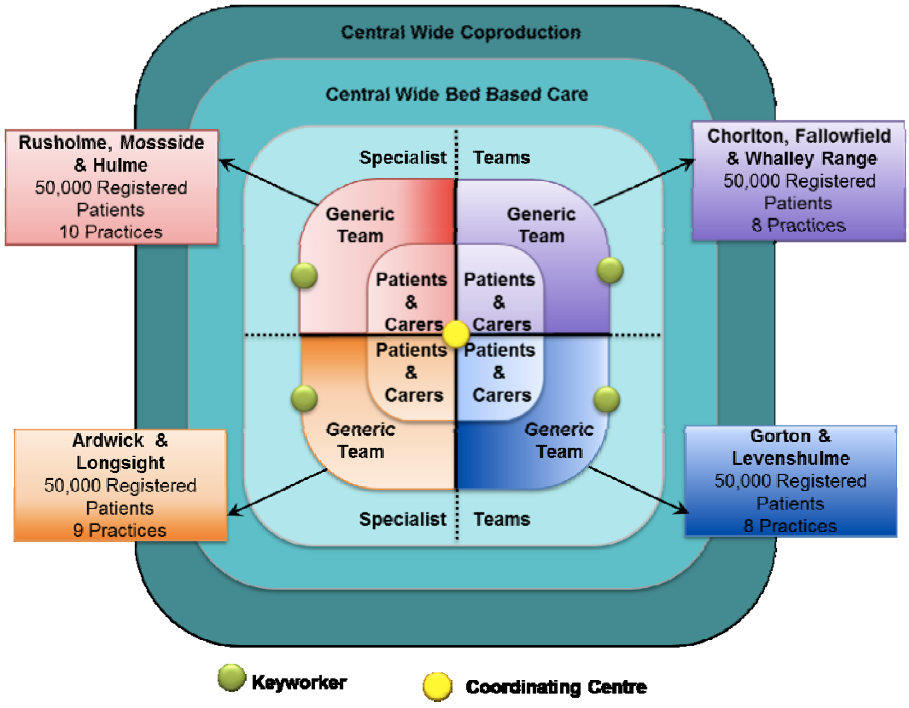
5.13 Common features across the new delivery models developed so far include:

- *Co-production with patients, carers and the community.* A model designed with and co-delivered by the people and communities that will use it.
- *Coordinated services* creating choice, independence and enabling care to be provided in the community.
- *Generic multi disciplinary teams* in each locality that can care for a person throughout their illness.
- *New diagnostic / assessment tools* used by patients/residents and providers across the system to more consistently identify needs earlier
- *Specialist team(s)* that will be able to give coordinate care to a patient and

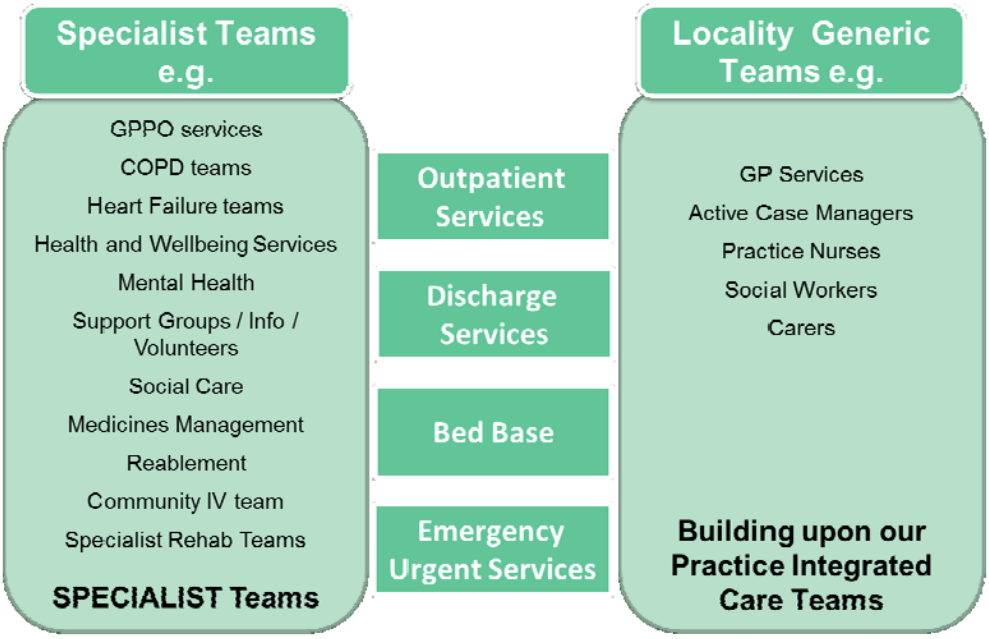
their carers in the community.

- *Carer Support* a physical and virtual service giving advice and information with identification of the carer and their needs at a generic team level.

5.14 Using Central Manchester (for illustrative purposes only) the high level delivery model is illustrated below:

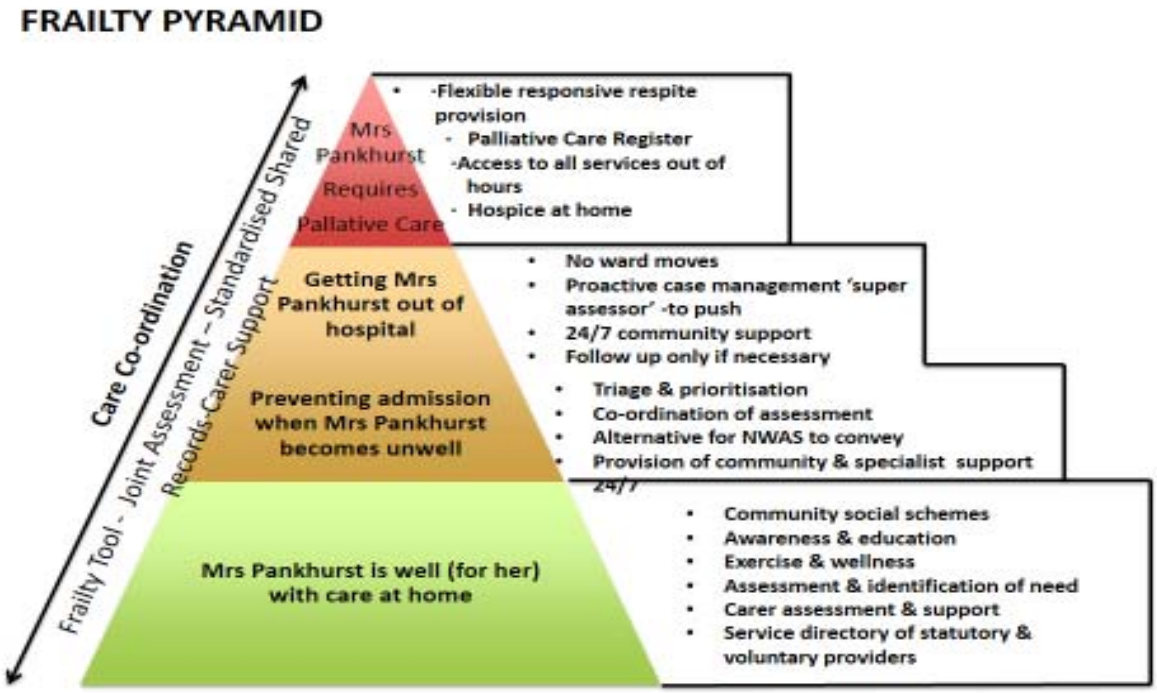


And in terms of the generic and specialist teams, this may include:



Examples of Specific Features by Care Model

5.15 The new delivery model design teams have looked at the specific interventions required for different levels of care. Using frail older adults in South Manchester as an example, the new delivery model design teams have looked at each stage of the care required for the population group, from prevention and early intervention to specialist care in the hospice or hospital. The high level model and its key features are illustrated below. It is important to note that tools such as the frailty tool will be used across the system, not just for health and social care professionals but for patients, carers and the voluntary sector to use.



5.16 Further practical examples of the new delivery models detailed in the Annexes include the following (recognising that each locality is at a different stage in developing new delivery models and may not represent delivery across all localities):

Frail older people and people with dementia	• Establishing a centralized information and support hub • Delivery through integrated multi disciplinary teams (building on the teams already on roll out) • specialist teams to provide more outreach to communities including consultants • 24/7 district nursing and reablement/ intermediate care • early identification of frailty using a frailty tool and GP register • one assessment / care plan - co designed with the person and their families and shared across all agencies

Adults with long term conditions	• shared assessment and care plan (owned by the patient) • care close to home • community assets to support self awareness and care and the development of community volunteer infrastructure • integrated multi disciplinary teams (building on the teams already on roll out) consisting of GP, community nursing, social work • response across 24 hours • support to carers to continue to care • access to pharmacists out of hours, NWAS • specialist outreach teams --linked to other care groups – enabling education of the patient, carer and workforce • build on self care approach
People at the end of life	• one care coordinator -- for consistent care • one year before end of life and support to families and carers after their relative dies • 24/7 support • care close to home or at home is also residential and nursing care) • Generic integrated team consisting of GP, nursing, social work • Access to equipment, assistive technology • Flexible team to respond as required to changes in need • Key worker for consistent and coordinated care --to be the link across primary and secondary care • Wishes are followed by all agencies including out of hours and NWAS • step up and down support as needed • bereavement support

Real Life Case Study: Delivery of Integrated Care through Multi-Disciplinary teams

Background

Anne has multiple long term conditions and very complex health and social care needs. She has recently been in hospital in October and again in November and has been commenced on new medication. She has complained of feeling very tired and now mobilises with a stick. Her husband is her main carer and she has a very supportive family who she sees regularly.

PICT Involvement

Anne was known to her GP, but the case summary discussion within the PICT meeting showed that she was not known to other members of the core team. As it seemed that one of her primary needs would be to stabilise her health conditions Anne was allocated to an Active Case Manager (ACM) at the PICT multi disciplinary meeting.

The ACM contacted Anne and met with her at home with her husband. Through the care planning process together they identified a number of priorities:

- To reduce her risk of readmission to hospital through supporting her and her husband around her blood levels and physical condition
- To liaise with the diabetic team around monitoring of Anne's blood glucose levels
- To make accessing outside her home easier due to there being steep steps at the front door and problems parking at the front of the house
- Support around monitoring weight, with a plan for what to do if her weight increased, due to the risk of fluid gain which may trigger a further unplanned admission
- Assistance in maximising benefits as Anne was not claiming her full financial entitlement.
- Education around the importance of foot care in diabetes, and the need to link in with podiatry services.
- To establish the cause of recent incontinence and to ensure support from the incontinence team to maintain dignity at home.

Together a plan was also put in place for what to do in a crisis situation, this included:

- For contact to be made with the ACM should Anne experience a 2kg gain in fluid over 2 days
- For a plan around Anne's platelet levels to be put in place, with guidance given around a stable level and what action to be taken should levels decrease further.

What this means for Anne:

- Anne has avoided further admission due to the self monitoring and professional monitoring she has received, putting her and her family more in control of her health.
- Anne's crisis plan has been tested and action taken in a timely way to prevent her health deteriorating to the point where she needed to go to hospital when her blood glucose levels became unbalanced.
- Anne has been able to receive the support of a range of different core and specialist health and social care services via her keyworker.
- Both Anne's needs and her carers have been recognised and planned around.
- Anne has had the opportunity to discuss and resolve issues not only around her crisis needs but also a number of less critical issues which were still of really high importance to her and her family, such as how to be able to get out and about more easily.
- Anne's plan has been built around her and the support she receives from her family, giving her more opportunity to be in control of her health conditions and feel more empowered.

What this means for Practitioners:

- Better sharing of information to enable a rounded view on the issues Anne has been experiencing and the support she may benefit from receiving.
- The opportunity to ensure more easily that the right skills are brought in at the right time to support people.
- A more easily accessible network of support to help in resolving problems.
- Shared ownership of decision making around Anne's plan, making sure that lost opportunities for support are minimised.

What this means for the System:

- An already tested care plan which has avoided admittance to hospital.
- Reduced duplication in support from different professionals.
- The promotion of self management, with Anne being supported to have clear responsibility in taking forward many of her care plan recommendations.
- A plan which not only responds with guidance on what to do in an emergency, but also has a strong emphasis on preventing Anne's condition from deteriorating in the first place.

Resident Involvement in Service Design

5.17 Partners in the development of the new delivery models are committed to the principles of co-production, involving residents throughout the design and delivery process. In designing a new way of working, partners will address the aspects of co production as outlined by the Social Care Institute for Excellence (2013).

5.18 Co-production is much more than just going out to consultation or co-creation where service users are involved in design. It is about seeing service users as equal partners with shared power and involving them in design, delivery, decision making and evaluation. To do this properly there will need to be radical changes to culture, structure and practice and this change will need to be accompanied by movement of resources to the people using services and frontline staff.

5.19 Co-production will need to run through the culture of our health and social care partners and a shared understanding about what coproduction are the principles for putting the approach into action and the expected benefits and outcomes will need to be agreed. Organisations will need to develop a culture of being risk aware rather than risk averse.

5.20 Partners have started the co-production process as part of the new delivery model design work, with a resident feedback event held in Manchester in December 2013 with 80 attendees. This included the following feedback on the 'as is' and the proposed future delivery models.

Frail older people and people with dementia

1. How well do you think health and social care services work for care of older

adults now:

3% good
13% average
32% poor
18% very poor
12% don’t know.

2. When asked after hearing about the new care model what do you think.

40% said it would improve things for patients and carers
20% said it would not make a difference for patients and carers
5% said it would make things worse for patients and carers
23% were not sure

Adults with long term conditions

1. How well do we do think health and social care work now for people with long term conditions?

1% excellent
4% good
45% average
24% poor
8% very poor
6% don't know

2. After hearing about the proposed new delivery model, what do you think?

44% said it would improve things
17% said it would not make a difference
0% said it would make it worse
21% were not sure

People at the end of life

1. How do you think Health and Social care services work for the end of the life care now?

19% good
9% average
12% poor
21% very poor
22% don't know

2. After considering the proposed future care models people said:

40% said it would improve
3% said it would not make a difference for patients and carers
9% said it would make things worse
19% were not sure

6. Developing the Financial Case

Financial modelling of the programme

6.1 The financial plan and business case for the integrated care models have to be developed in the context of the anticipated financial position for the Council and the three Clinical Commissioning Groups over the next five years.

6.2 The health sector challenge has been widely communicated across the Manchester health economies. The significant task of reducing and managing the city's financial pressures is being addressed through a variety of inter-dependent programmes, namely:

- Healthier Together
- Integration
- Primary Care Strategy
- Other 'Quality, Innovation, Prevention and Productivity' (QIPP) schemes

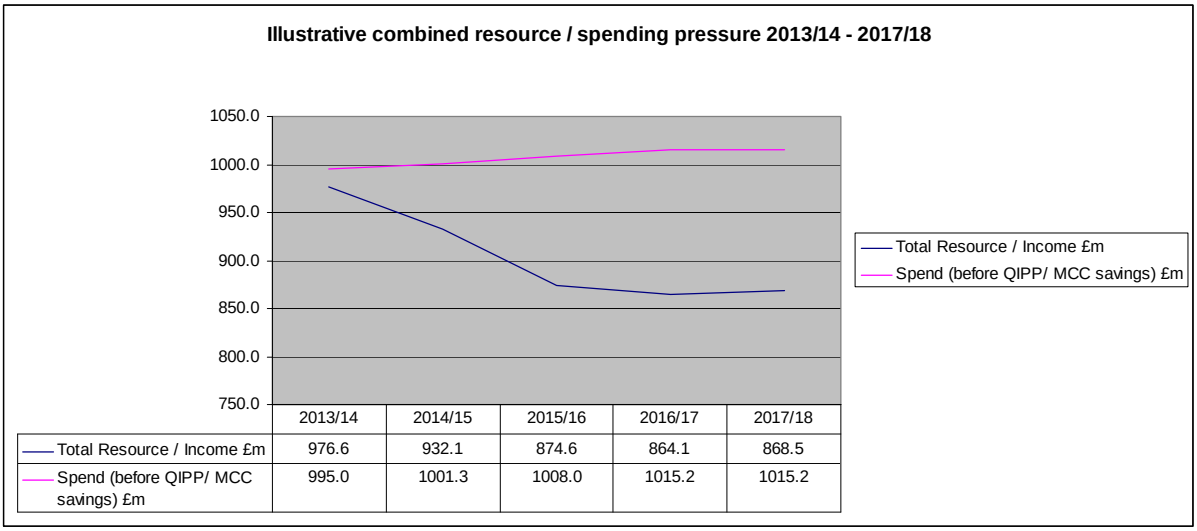
6.3 Recognising the range of programmes running in parallel and the ongoing modelling work for each, the precise implications for the acute (and other) sectors are not fully quantified at this stage. Work has been undertaken to ensure that assumptions remain consistent between the various aspects of planning wherever the scope of modelling is similar.

6.4 The financial pressure for Adult Social Care has been estimated to reach £70m by 2017/18 based on the current spend profile. Savings for 2014/15 have already been agreed and relate to efficiency and demand management within the Council. The financial envelope for new integrated care models will be defined as part of the development of the Council's Medium Term Financial Plan for 2015/16 and 2016/17 during 2014. This will take account of the impact of the Care Bill from April 2015 and the Children & Families Bill in relation to children with long term conditions.

6.5 Through the LLLB programme, new delivery models (NDMs) of care are being developed for five priority population groups. The financial models will include the recurrent cost of delivery, implementation costs and anticipated transitional support. They will also set out the efficiencies expected to be achieved and other benefits realisation plans.

6.6 A series of strategic financial planning assumptions are being agreed with key partners to guide the range of affordability during development of the new delivery models. These reflect the activity shift assumptions expected to be delivered through the above programmes over the planning period, as well as acknowledgement that reinvestment will be required in community and other services to secure reductions in hospital capacity. Mitigation for non-achievement will need to be identified and agreed as part of this.

6.7 The graph below sets out the overall financial gap across health and social care. It indicates a need to reduce costs by £133m by 2015/16 to meet potential funding reductions and meet pressures and £147m by 2017/18[3].



	2013/14	2014/15	2015/16	2016/17	2017/18
Total Resource / Income £m	976.6	932.1	874.6	864.1	868.5
Spend (before QIPP/ MCC savings) £m	995.0	1001.3	1008.0	1015.2	1015.2

The Better Care Fund

6.8 The Autumn statement set out the flexibility available to support local areas to deliver services differently, in particular the use of pooled funding for the integration of the health and social care system and the introduction of an integration Transition Fund (ITF) now known as the Better Care Fund (BCF) for 2014/15 and 2015/16. The Better Care Fund will be drawn upon by the collective economy to finance the costs of implementing an integrated health and social care system.

6.9 Given the number of interdependent efficiency and improvement programmes outlined above and the role each has to play in delivering a share of the combined financial pressure, only a proportion of the CCGs' and City Council's budgets will be included within the formal section 75 agreement for the Better Care Fund.

[3] To be revised following recent publication of funding settlements

6.10 This is illustrated through the financial settlement in December 2013 that provided financial allocations for the BCF for 2014/15 and 2015/16 as follows:

Better Care Fund Allocation	**2013/14 £0**	**2014/15 £0**	**2015/16 £0**
Better Care Fund Allocation			
Carers break and reablement	5,000	5,000	5,000
Social care transfer	9,542	12,219	12,219
Disabled Facilities Capital	2,967	2,967	2,967
Social care capital	1,485	1,485	1,485
NHS funding transfer/integrated care	5,100	5,100	20,419
	24,094	**26,771**	**42,090**
Less			
BCF committed to existing services	-18,994	-19,450	-19,450
BCF committed to NDM pilots	-5,100	-5,100	-5,100
Est Impact of Care Bill from Apr-15			-2,000
	-24,094	**-24,550**	**-26,550**
Plus			
CCG additional investment		tbc	tbc
Council additional investment		tbc	tbc
		tbc	**tbc**
Total available for New Delivery Models	**0**	**2,221**	**15,540**

6.11 The CCGs and City Council have identified baseline expenditure (base year 2013/14) on services covered by these resources. This includes the costs of a range of existing services (for example, reablement, intermediate care). These existing services are within the overall financial envelope for the full programme for the five priority groups.

6.12 The vast majority of 2013/14 resources are already committed recurrently. However, the final scope of commitments to be included in the BCF will be collectively and formally agreed in February of 2013/14 by the Health & Wellbeing Board.

6.13 The BCF will be drawn upon to properly finance the short, medium and longer term costs of implementing an integrated health and social care system. In addition, the Local Authority will expect to fund the implications of the 'Care Bill' via the additional social care funds transferring from 1 April 2015.

6.14 The expected BCF to be available for further development, implementation and transition costs of new integrated models is £2.221m in 2014/15 and £15.540m in 2015/16. The recurrent investment in 2015/16 relates to the NHS funding transfer of £20.419m which is marks a significant indicative shift of resources from the Acute sector to the LLLB programme. Further investment from the CCGs and City Council for 2014/15 is currently being agreed locally.

6.15 The investment of the BCF into the development of the integrated models during 2014/15 and 2015/16 will be set out in the BCF submission to the Department of Health (DH) on 14th February 2014. The submission will also include the expected performance improvements and any cashable savings from this investment during 2014/15 and 2015/16. The performance measures have been defined by the DH, but can also include locally developed measures that support the overall programme. The DH has indicated that the success of the programme in improving performance during 2014/15 will impact on circa £10m of funding for the BCF from April 2015.

Cost Benefit Analysis

6.16 Partners recognise that prior to implementation of new ways of working, business planning procedures and supporting Cost Benefit Analysis (CBA) techniques must be carried out to assess the feasibility of each NDM, in terms of quality and outcomes, patient experience, and cost effectiveness for the taxpayer. It is also acknowledged that a range of transitional costs will be incurred as the health and social care systems respond to the new approaches.

6.17 The timing and level of investments required (recurrent, non-recurrent and transition costs) will be driven by the pace of development of the five new delivery models in Manchester as well as the underpinning service business cases and necessary consultation periods.

6.18 A financial model has been developed to capture current health and social care expenditure across the five priority target population groups, through a combination of service cost mapping and a financial model developed for the purposes of the LLLB programme. This model is being refined and will form the basis of the formal Cost Benefit Analysis for the next wave of investment in the NDMs between January and February 2014 (and beyond).

6.19 Comprehensive expenditure plans for all of the new delivery models are not yet in place in each of the next five financial years. This reflects the complexity and scale of the integration agenda, as well as the number of models being developed in parallel across Manchester.

6.20 Despite this challenging context, there is a pressing need to develop business cases at pace given the changes in BCF resources in the next two financial years. This will help to ensure that resources will be utilised promptly to

support implementation and realise the potential benefits of the new delivery models.

6.21 High level next steps for the finance element of the programme is as follows:

- Ongoing development of the financial model and delivery of the actions within the finance workstream
- Agreement of financial envelopes by commissioners following release of planning guidance and settlements.
- Bottom up financial modelling based on new delivery models on a phased basis
- Confirming Healthier Together assumptions, shifts/deflections and acute provider assumptions regarding efficiencies
- Agreement of BCF / Development Fund to identify resources to support the transition

7. Developing our Contracting Approach

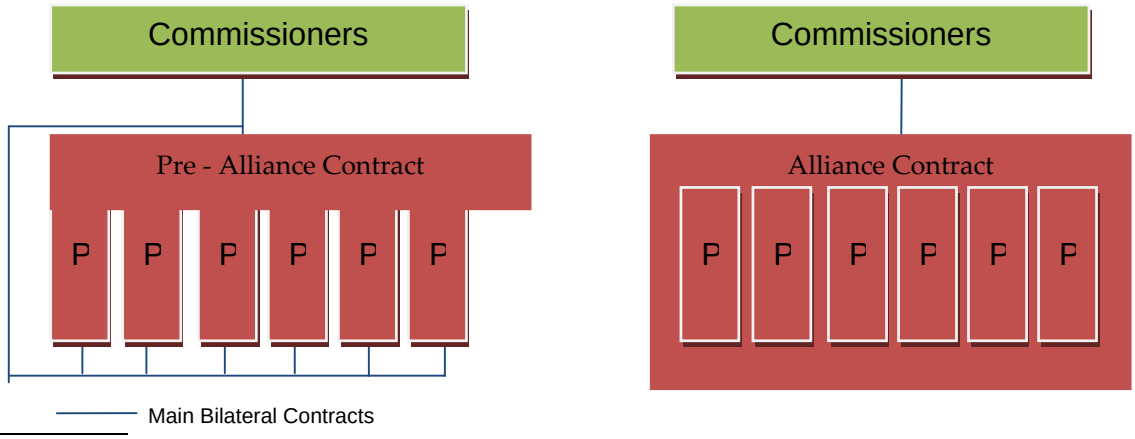
7.1 New contracting arrangements are in development in each of the three localities aimed at facilitating the integration of care. These will bring closer contractual alignment enabling health and social care partners to work towards and get rewarded for achieving common goals.

7.2 The depth of contractual integration can vary and will be phased, with 2014 providing a testing ground before new approaches are fully adopted. This will also allow for contracting arrangements to develop mirroring any developments in the new delivery models.

7.3 One of the options being considered for 2014 is a memorandum of understanding agreed by providers and commissioners that sets the principles for working together to deliver integrated care, along with a shared performance framework for providers. This would represent a first step towards contractual alignment and is being considered by North Manchester. Shadow arrangements for closer integration (for example shadow financial arrangements whereby providers are rewarded for achieving integrated care goals) could be run alongside this, again providing a safe testing ground before adopting such approaches for real.

7.4 Central Manchester intends to go further and sign a 'pre-alliance contract' for urgent care services, agreed by commissioners and providers, that includes financial incentives in addition to a shared performance framework.[4] Under this arrangement, each provider organisation will retain its existing bilateral contract with its commissioner for a significant proportion of the contract value and the remainder would be part of an alliance contract between the commissioner and the partnership of providers. Some of this contract value would only be paid by commissioners depending on whether the shared performance measures were achieved. The intention would then be to implement a full alliance contract from April 2015.

Pre-alliance contract versus 'full' alliance contract



[4] Central Manchester intends that the full alliance agreement in 2015 is built around the new delivery models for the population groups. However until the new delivery models are up and running there is too much uncertainty around their associated costs and activity levels to be able to draw up an effective pre-alliance contract.

7.5 Other potential options for contracting include a single accountable care organisation and prime contractor models. These are not being looked at for 2014 but remain potential options for 2015 and beyond.

7.6 Central Manchester have established formal project arrangements to develop their contracting approaches with workstreams covering governance, finance, performance and contract development. The plan is to finalise contracting arrangements for 2014 by late February / early March which is tight but achievable. North and South Manchester are developing similar project management arrangements to develop their contracting approach.

7.7 In developing the new contracting arrangements, commissioners are assessing the implications for competition, service users and procurement. This is to ensure options deliver the best value in terms of outcomes per pound spent as well as ensuring legal and regulatory compliance.

8. Evaluation of the Partnership Approach

8.1 The work around measurement of health and social care outcomes needs to run in parallel to a broader evaluation of the LLLB programme as a whole, including some consideration of the effectiveness of the Manchester model of partnership that underpins the development of LLLB at both organisation and system level. Given the scale and complexity of the LLLB programme, we are seeking to utilise the academic links that exist through the Manchester Academic Health Science Centre (MAHSC) in order to enlist the support of academic colleagues from across a range of University departments in order help us formulate, and potentially carry out, an evaluation of the LLLB programme.

8.2 The University is also keen to explore synergies with the Greater Manchester Integrated Care Programme with a view to identifying if there are any economies of scale across the conurbation in terms of a common approach to evaluation. Manchester is well placed to exploit any opportunities that arise at Greater Manchester level and to that end we have offered to help to facilitate a meeting between the University and the Greater Manchester Integrated Care Team with a view to using Manchester as a pilot site to test out any evaluation methodologies/approaches that could later be applied to other areas. This would give us the academic support we need for our own local evaluation whilst setting this firmly within the context of a Greater Manchester approach to evaluation.

8.3 The evaluation of the programme is being developed further so that it can be more clearly defined and an appropriate methodology identified. We expect to receive a proposal from the university shortly which will describe the range of external support it can provide and quantify the investment required from the LLLB programme partners. A rigorous and independent evaluation will derive extremely useful evidence about the approaches taken and how these can be applied throughout the lifetime of the programme and elsewhere nationally.

9. Stakeholder Engagement

9.1 The proposed Communications Strategy (attached as annex five) plans a programme of communication and engagement activity which explains how health and social care organisations in the city are working to develop services which are consistent, high quality and designed around the needs of Manchester's residents. The narrative is in three parts:

a) Description of the high level context
b) Description of a new vision for services delivered where they're needed, when they're needed. This will some detail of how the services will function and the standards the services will meet. The 'in hospital' content will be developed in partnership with the Healthier Together team to ensure a consistent message is delivered across Greater Manchester.
c) Details of programmes of work to deliver the above including case studies and examples of services already implemented. These will help bring to life the plans and give concrete examples of how new services work. An example of a case study is available in Appendix C.

9.2 Throughout the dialogue, people will be encouraged to feedback their thoughts and comments. These will be captured during briefing sessions or via engagement mechanisms shared across partners. These will include the CCGs' engagement specific website www.talkinghealth.net which will act as a web based source of all relevant information. When specific programmes or services are being discussed, feedback may be sought on specific topics using specific mechanisms. These will be promoted as part of the communications activity described in the strategy.

9.3 Rather than being labelled as *Healthier Together* or *Living Longer, Living Better,* the 'conversation' will be carried out under the name A *healthier Manchester*. Existing programmes will retain their own identities but this approach will then enable all other programmes of work to be talked about as part of one thing as opposed to a range of disparate programmes.

9.4 The Strategy is split into 4 different phases:

Phase 1: Internal Stakeholders – January/February 2014
Phase 2: External Stakeholders – March /April 2014
Phase 3: Healthier Together led Public Consultation – June 2014
Phase 4: September 2014 onwards – continuing communications and engagement with all stakeholders to inform and engage them in the progress of our work.

Planning and Delivery

9.5 The Communications strategy has been planned and developed by the Communications leads from each of the Health and Wellbeing Board's partner organisations. For phase 1, each organisation will be responsible for delivery of the plan with common materials developed centrally to ensure a consistent narrative. A 'Question and Answer' log will also be maintained and made

available to Communications leads and key staff in partner organisations. Appendix D gives some idea of the questions we are expecting and which we will have responses to prior to the launch of the conversation. For phase 2 onwards, external communications will be managed centrally with contributions from partners as required.

9.6 At the same time as this work is being planned, the Healthier Together team is working with Communication leads across Greater Manchester to identify what messages regarding hospital reconfiguration should be disseminated. This work is ongoing and will influence the key messages. The strategy will be updated once these are confirmed.

10. Next Steps

10.1 Outlined below are priority thematic areas for the Programme over the next six months.

Stakeholder engagement
Taking forward the stakeholder engagement plan highlighted within this report with immediate partners, stakeholders and their employees, increasing the depth of understanding of the programme, its priorities and benefits to the city.

Developing new delivery models
Progressing the collaborative design work, increasing the granular detail of the models and moving towards practical implementation considerations.

Focusing on the enabling domains (estates, IT, workforce)
Good work has started across a number of the enabling domains, however without tangible details on the new delivery models they can only progress so far. Now that more details are being developed on the new models, work can accelerate on the supporting domains, alongside stakeholder engagement.

Financial analysis
Financial analysis of the new delivery models will continue over the coming months, now that the financial settlement for the lead commissioners are published and more granular detail is emerging from the new delivery models.

Implementation phasing and detailed planning
Bringing together the new delivery model and finance analysis as part of the Better Care Fund, work is underway to plan the detailed implementation of particular interventions and services described within the new delivery model development.

Governance
Developing the governance and roles at both a locality and city-wide basis for the Living Longer Living Better programme, alongside other reform programmes.

Programme management
Increasing capacity at a city-wide and locality/system level for the programme management of the Living Longer Living Better programme.

Outcomes and evaluation
Further development of the draft metrics to support the evaluation of the programme, including the care model specific outcomes and shifts (currently in draft form).

Annexes

Annex 1 – measures and metrics for the Living Longer Living Better Programme
Annex 2 – North Manchester New Delivery Models update
Annex 3 – Central Manchester New Delivery Models update
Annex 4 – South Manchester New Delivery Models update
Annex 5 – Communication Strategy

Annex 1 - LLLB assessment framework (draft)

Goal	Metric	Rationale	Scale of ambition	Timeframe	Data source	Current baseline (as at…)	Notes
Add years and quality to life	Healthy life expectancy at birth (PHOF 01i)	This indicator is an important summary measure of mortality and morbidity in the population served by local health and social care services.	England average	5 years	Office of National Statistics (ONS)	55.0 (Men) 55.4 (Women) (2009-11)	Based on the number of deaths registered in the calendar year and the weighted prevalence of people reporting good or very good health from the Annual Population Survey (APS).
	Potential years of life lost (PYLL) from causes considered amenable to healthcare (NHSOF 1a)	Deaths from causes considered 'amenable' to health care are premature deaths that should not occur in the presence of timely and effective health care. Therefore this is a good measure of the success of local health and social care services in preventing amenable deaths.	England average	5 years	Office of National Statistics (ONS)	3,125.9 (2012)	Can be broken down by gender or between children and young people (aged 0-19 years) and adults (20 years and over). Rates are directly standardised to the Europe Standard Population to allow for international comparison.

Improve health and social care outcomes in early years (0-4 years) in order to improve school readiness	% children achieving a good level of development at the end of reception based on EYFSP assessment	Increased focus on prevention and self management of care for children with LTCs in the community will reduce hospital admissions and improve school readiness.	England average	5 years	Department for Education	47% (2013/14)	Data based on the % of pupils achieving at least the expected level in the Early Learning Goals within the three prime areas of learning and within literacy and numeracy.
	% of Year 1 pupils achieving the expected level in the phonics screening check		England average	5 years	Department for Education	To be confirmed	
Enabling people to live independently at home	% of people who use services who have control over their daily life (ASCOF 1B)	Control is a key outcome for people who use health and social care services. By designing and delivering services that more closely match the needs and wishes of the individual, patients can be put in control of their own care and support. This metric is one way of determining whether that outcome is being achieved.	England average	5 years	Adult Social Care Survey	73.7% (2012/13)	Data drawn from Question 3a of the Adult Social Care Survey: "Which of the following statements best describes how much control you have over your daily life?"
	% of people helped to live independently		Increase by 2.5% by 2014 and by 7.5% by 2020	5 years	To be confirmed	Latest data to be confirmed	

	% of older people (aged 65 & over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services BETTER CARE FUND METRIC	Improving the effectiveness of these services is a good measure of the success of local health and social care services in terms of delaying dependency and reducing avoidable admissions.	England average	5 years	Adult Social Care Combined Activity Return (ASC-CAR) and Hospital Episode Statistics (HES)	63.4 (2012/13)	

Improve the quality of care and reduce the frequency and necessity for emergency admissions and care in hospital and residential / nursing homes.	Avoidable emergency admissions: composite measure of unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages), asthma, diabetes and epilepsy in children, acute conditions that should not usually require hospital admission (all ages) and children with lower respiratory tract infection. BETTER CARE FUND METRIC	Good management of long term conditions requires effective collaboration and shared responsibility across the health and care system to support people in managing their own conditions and to promote swift recovery and reablement after acute illness.	TBC when data released by NHS England in January 2014.	5 years	Hospital Episode Statistics (HES)	NHS England will provide baseline data at local authority level in January 2014.	The composite measure will match that used in the Quality Premium except that it will be based on local authority resident populations rather than the CCG/GP registered population. About a third of avoidable admissions are for people with a secondary diagnosis relating to mental health so progress in reducing avoidable emergency admissions is likely to need a strong focus on improving the physical health of people with mental health conditions.

	Ambulance services (% of emergency patient journeys to destinations other than Type 1 & 2 A&E)		England average	5 years	North West Ambulance Service	5.5% (2012/13)	Data relates to the whole of the NW region. Will be replaced with data for patient journeys within Manchester if available.
	A&E attendances		10% reduction	5 years	SLAM (Month 6)	269,980 (FOT 2013/14)	Figures are based on aggregate of 3 CCGs and reflect the assumptions that Directors of Finance have agreed in terms of reducing hospital activity over the next 5 years. Totals exclude excess bed days, OP procedures, mental health and obstetrics activity
	Non-elective admissions		20% reduction	5 years	SLAM (Month 6)	50,014 (FOT 2013/14)	
	Elective admissions (day cases plus inpatients)		8% reduction	5 years	SLAM (Month 6)	55,732 (FOT 2013/14)	
	Outpatient appointments (first & follow-up)		16% reduction	5 years	SLAM (Month 6)	444,230 (FOT 2013/14)	
	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population (ASCOF 2A)	Avoiding permanent placements in residential and nursing care homes is a good measure of the success of local health and social care services in delaying dependency and working together to reduce avoidable	England average	3 years	Adult Social care Combined Activity Return (ASC-CAR) and the Office of National Statistics (ONS)	821.8 (2012/13)	People are only included in this metric where the care is paid for, in whole or in part, by MCC and where the intention at admission is for their care to be permanent. Transfers from

	BETTER CARE FUND METRIC	admissions.					temporary to permanent care are also included.
Increase spend and volume of out of hospital services	Primary care Measure to be agreed	Shift of care (and spend) away from a hospital setting should allow for reinvestment in out of hospital services.	England average	5 years	To be agreed	To be agreed	
	% of service users in receipt of community based services		To maintain current levels of take-up or manage the increase in need within 5 to 10% increase	5 years	To be confirmed	Latest data to be confirmed	This is a snapshot measure which looks at the no. of people receiving community-based services as a % of the total number of people receiving (community-based care & residential and nursing care) services on the last day of the period.
Increase effectiveness of joint working between local partners	Average total monthly delayed transfers of care (attributable to either NHS, social care or both) per 100,000 population. BETTER CARE FUND METRIC	This is an important marker of the effectiveness of joint working between local partners and of the effectiveness of the interface between health and social care services.	England average	5 years	Delayed Transfers of Care Return (NHS England)	217.3 (June – Nov 2013)	Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'monthly snapshot' collected for one day each month.
Improve experience of	Proportion of deaths at home/in	Development of hospice at home	England average	5 years	Office of National	Latest data to be confirmed	Routinely available but may be issues

patients/carers at end of life	place of choice	services will enable more people to die at home or in their place of choice.			Statistics (ONS)		with splitting death data by care model groups.
Carer-reported quality of life	Average quality of life score reported by carers. BETTER CARE FUND METRIC	This measure gives an overarching view of the quality of life of carers and supports a number of the most important outcomes identified by carers themselves to which adult social care contributes.	England average	5 years	Carers' Survey (Questions 7 to 12)	8.0 (2012/13)	The Carers' Survey is a biennial survey. 2012-13 is the first year for which measures based on the Carers' Survey are available.
Patient/service user experience	National metric (currently under development) BETTER CARE FUND METRIC	Effective engagement of patients, the public and wider partners in the design, delivery and monitoring of services gives patients, carers & their families a better understanding of their conditions and treatment plans to achieve better outcomes; increases understanding of patients and the public about health and social care services; empowers communities to have a say in the delivery of	TBC when national metric released	5 years	TBC when national metric released	TBC when national metric released	National metric currently being developed
Improve patient/carer experience of secondary care (inpatient and A&E)	% recommending the NHS service they have received to friends and family who need similar treatment or care ('Friends and family test') – combined A&E and inpatient rates		England average	5 years	Unify2 Data Collection, NHS England	63% (CMFT) 52% (PAHT) 82% (UHSM) (November 2013)	Concerns about validity of data given that the response rate is currently very low. May be hard to split data by care model group to look at satisfaction of services among frail older people, adults with long term conditions etc

Improve patient/carer experience of primary care (GP and out of hours services)	Patient experience of GP services (NHSOF 4a.i) Note: To be replaced by 'Friends and family test' when introduced in this setting	local services and encourages better decision-making and leads to more effective service delivery.	England average	5 years	GP Patient Survey (NHS England and Ipsos MORI) based on data for Jan-Mar and July-Sept 2013)	84% (NMCCG) 83% (CMCCG) 84% (SMCCG) (Dec. 2013)	The GP Patient Survey provides information on patients' overall experience of primary care services and their overall experience of accessing these services. These indicators are calculated as the % of people responding "Fairly Good" or "Very Good" when asked to describe their overall experience of their GP surgery and of out-of-hours GP services.
	Patient experience of GP out of hours services (NHSOF 4a.ii)		England average	5 years	GP Patient Survey (NHS England and Ipsos MORI) based on data for Jan-Mar and July-Sept 2013)	66% (NMCCG) 66% (CMCCG) 67% (SMCCG) (Dec. 2013)	
Improve patient/carer experience of community health services	'Friends and family test' to be used once it has been introduced in this setting		England average	5 years	To be agreed	To be agreed	Is there a routinely available measure of satisfaction with community services?

Improve patient/carer experience of social care / support services	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	The satisfaction with services of people using adult social care is directly linked to a positive experience of care and support. As such, this measure is a good predictor of the overall experience of services and quality.	England average	5 years	Adult Social Care Survey	66.5% (2012/13)	This data is drawn from Question 1 of the Adult Social Care Survey which asks: "Overall, how satisfied or dissatisfied are you with the care and support services you receive?"
	Overall satisfaction of carers with social services (ASCOF 3B)	This satisfaction with services of carers of people using adult social care is directly linked to a positive experience of care and support. This measure is therefore a good predictor of the overall experience of services and quality.	England average	5 years	Carers Survey	43.1% (2012/13)	This data is drawn from Question 7 of the Carers Survey, which asks: "Overall, how satisfied are you with the support or services you and the person you care for have received from Social Services in the last 12 months?"
Improve satisfaction of workforce with new delivery models	Measure to be agreed		England average	5 years	To be agreed	To be agreed	

The Pennine Acute Hospitals NHS
NHS Trust

Living Longer, Living Better

1.0 Introduction

1.0.1 This paper describes the progress towards the development of new delivery models and the Living Longer, Living Better in North Manchester. We recognise that this is an ambitious programme and therefore we understand there is still work to be done. The health and care economy is working together to achieve a vision of care which is coordinated around the individual needs of the person, supports independence and is provided at the most appropriate location.

2.0 Background

2.0.1 The care models identified for early delivery model development will result in proposals for a set of services from a range of providers that will work together to offer the care needed to achieve the required outcomes for the following groups of people in our population. Three (*) have been identified locally as priority areas for development of new delivery models.

- Adults with long term conditions*
- Frail older adults and adults with dementia*
- End of life care*
- Adults with complex needs
- Children in their early years

2.0.2 The care models define a set of expected outcomes, a description of what will be different for North Manchester residents, along with the expected system standards and measures for success.

2.0.3 We are fortunate that some of the potential interventions of the new delivery models are well into implementation and have already delivered demonstrable improvements for the population of North Manchester. Some are at an early stage of design and we will utilise the freedom and flexibility to innovate to develop full new delivery models that can meet the requirements laid out in the care models.

3.0 Building successful Provider Partnerships

3.0.1 It is acknowledged that design of new delivery models needs to be with full engagement of a much broader range of potential providers. In October 2013 The North Manchester Health and Social Care Community Clinical Board agreed that Pennine Acute Hospitals Trust would lead in facilitating a provider partnership in an appropriate structure locally. This does not assume

leadership of a new delivery model or future leadership of the partnership of providers.

3.0.2 A provider partnership forum was established in December 2013 and will be expanded to ensure the full ranges of potential health and care providers are able to engage fully. This forum will be crucial in the accountability and governance of the design and agreements of new models.

3.0.3 The forum will oversee and steer the design of the new delivery models in North Manchester's health and social care system. In doing so the provider partnership will build upon the work of the former Transforming Community Services Committee and the work of the North Manchester Health and Social Care Community Clinical Board work programme.

4.0 North Manchester - Living Longer, Living Better

4.0.1 We are building on our integrated care activities, where they have brought about improvements in the care and experience for North Manchester residents, as we develop full new delivery models. By working collaboratively as a health and care system we have a legacy of developments and committed plans to date which have seen positive results.

4.0.2 Hospital activity in North Manchester has reduced in a number of key areas, against planned (broadly based on last year's outturn). Activity levels as at month 7 included:

- A&E attendances 3.3% below plan
- Non-elective admissions 10.8% below plan

4.0.3 Although the activity now seen through the North Manchester Treatment Centre accounts for a significant proportion of the reduction in non-elective admissions, activity has fallen at North Manchester General Hospital (NMGH). The Treatment Centre is the local successful model for the delivery of ambulatory emergency care. This provides a highly effective and more efficient way of treating those conditions which are appropriate for sensitive to ambulatory care.

4.0.4 We are also seeing the impact of improvements in ensuring timely discharge for people, helped by there being an integrated health and social care discharge team under single management at NMGH. This is highlighted by reductions in excess bed days (days over and above what would be expected for each type of admission)

- Non elective excess bed days 30% below plan
- Elective excess bed days 31.1% below plan

4.0.5 We know transforming our care system to enable all people in North Manchester to live longer and better lives is a programme of reform that will require further work. We are pleased that the partnerships of providers and commissioners are committed to this aim. As we build on what we have achieved we will make space for creativity, enabling others to continue or build on their contribution e.g. carers.

4.0.6 There are already a range of services and interventions, existing and planned, that we believe are well placed to contribute to the prioritised early new delivery models. A number of these are highlighted below.

4.1 Integrated care for the elderly

4.1.1 The development of a focused care of the elderly service that brings together and builds on existing provision including: Navigators, Ambulatory Care, DayCare, North Manchester Integrated Care Teams, Inpatient Assessment, Podiatry, Rehabilitation, Reablement, Extra Care, Sheltered Housing, Enhanced Intermediate Care, Mental Health Care, Community Physiotherapy, Palliative Care. This would be aimed at preventing unnecessary admission, reducing length of hospital stays and maximising reablement.

4.2 Integrated Health and Social Care Discharge Team

4.2.1 The team which is based on ward D3 at North Manchester General Hospital brings together staff from The Pennine Acute Hospitals NHS Trust; Bury, Rochdale and Manchester Councils; North Manchester Clinical Commissioning Group and the voluntary sector. The unit which was opened in January 2013 is able to provide better support and care for people with long term or complex health and social care needs by providing a more streamlined, seamless and integrated experience. The service has introduced better ways of tracking and monitoring patients', from the time they are admitted, right through to discharge and follow on care.

4.2.2 By sharing resources and expertise, the integrated team makes better use of financial resources and improves the overall user experience. This is done by speeding up the discharge and readmissions process, which ultimately aids the recovery and rehabilitation, whether that be at home or in the community. The team works to improve access to care by changing the way that services are delivered. By reducing duplication of assessments and interventions, patients are ensured of their care at the right time by the right professional.

4.2.3 The service is a positive example of how partner agencies can come together to overcome any barriers for those with the most complex health and social care needs.

4.3 North Manchester Integrated Neighbourhood Care Teams

4.3.1 The population of the UK is ageing and increasingly people are living with complex, long term conditions. To be able to respond to this it is vital that health and social care services work together to transform the way that care is provided, to enable people to have an improved quality of life and to make the best use of resources.

4.3.2 In North Manchester, we have been developing Integrated Neighbourhood Care Teams (NMINC). These teams include both health and social care professionals who work together across primary, community social and

specialist acute services for patients with the greatest likelihood of future admission to hospital. They provide a coordinated plan and care for people with complex conditions who are most likely to benefit from the teams involvement.

4.3.3 The NMINC strategy has three drivers:

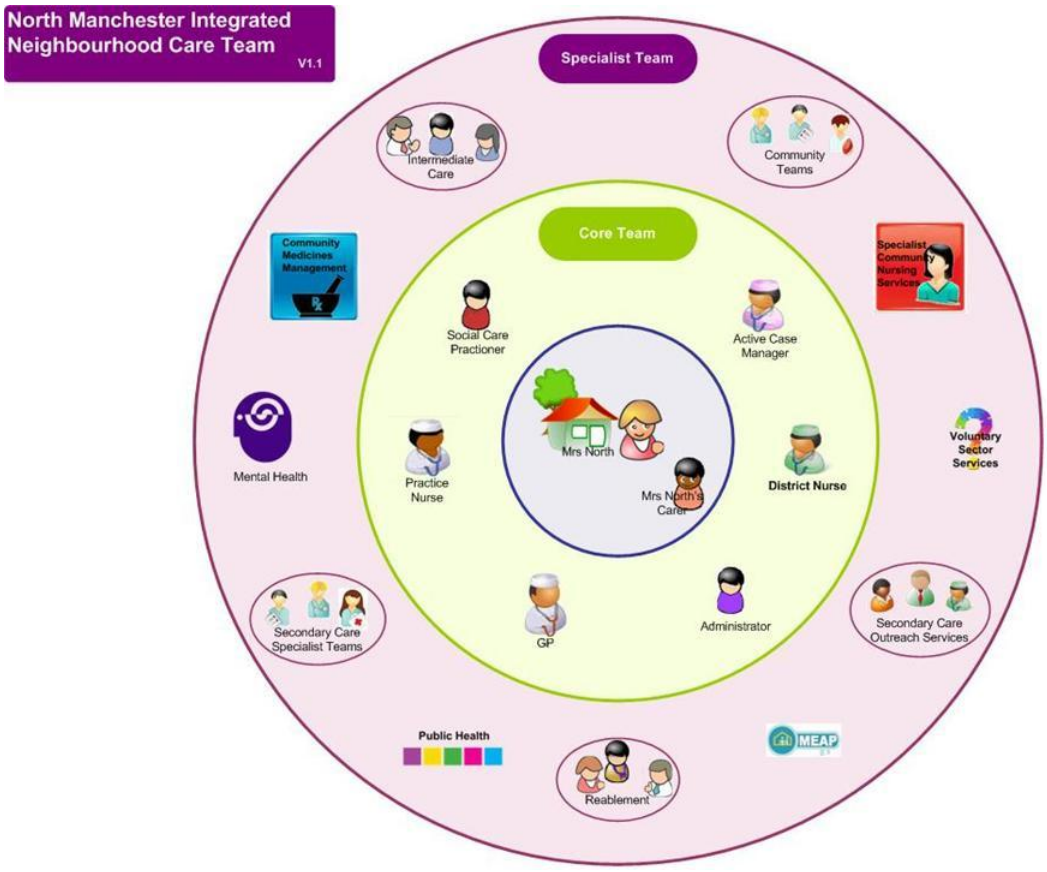
- Using a risk stratification tool to identify those people most at risk of hospital admission
- Having integrated health and social care teams to proactively manage risk stratified cohorts of people
- Developing a systematic approach to enable and support self care

4.3.4 The basic framework for NMINC is as follows:

- Targeting high or moderate risk adults (over 18 years old), using risk stratification (based on a tool called the Combined Predictive Model).
- Minimal exclusions, for example, people who are acutely ill, people who have now stabilised
- Care based around the practice – the GP is the lead clinician
- A 'core' team – GP, Practice Nurse, District Nurse, Active Case Manager, Social Worker
- Regular multidisciplinary team meetings
- Identifying pathways to other support, including social prescribing
- Key worker/case manager model – collaboratively agreed
- Collaborative care planning and review
- Time limited - closure around 12 weeks

4.3.4 As a result,

- People will receive appropriate, high quality care provided by the right person, in the right place, at the right time. This includes an intensive short term planned intervention to provide a coordinated plan to improve the patient's condition and maximise independence and self care
- There will be improved joint working between practitioners, resulting in better understanding of roles, increased sharing of knowledge and better management of expectations across professions.
- There will be more efficient and focused use of existing resources.

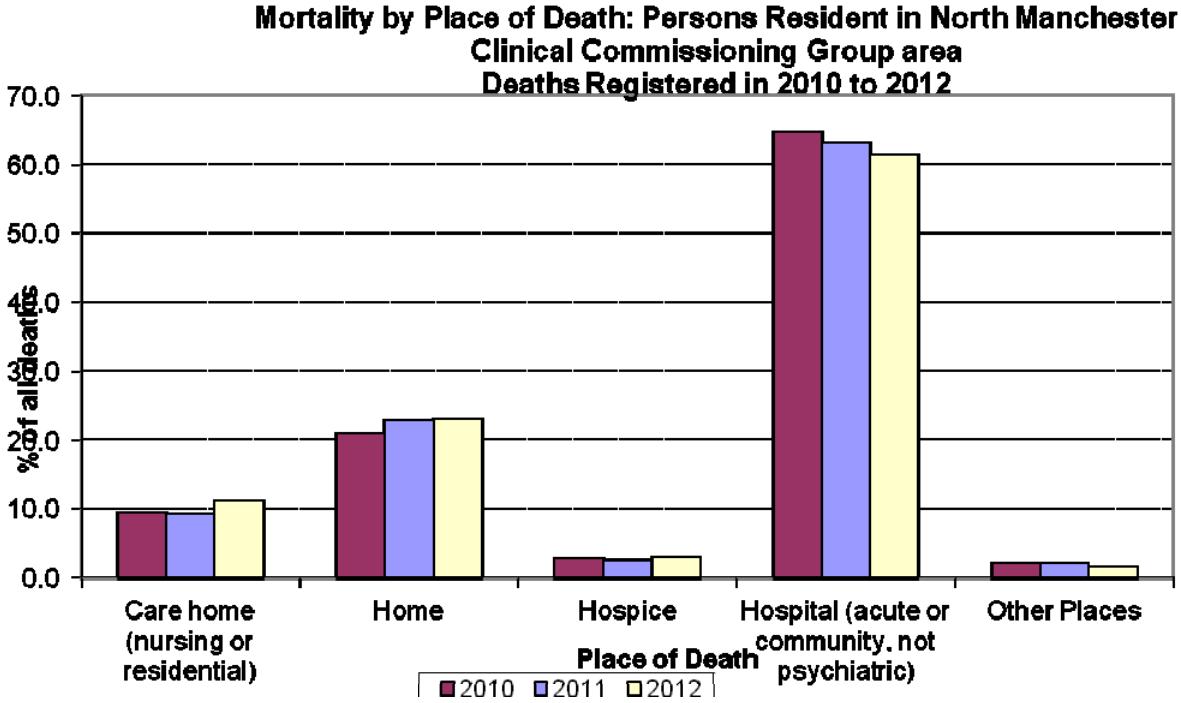


4.3.5 We are now concentrating on developing the 'wider specialist team' and rolling out the model by June 2014 to all practices across the four neighbourhoods in North Manchester. Implementation of NMINC has been enabled by the collaborative approach between health and care partners along with supported investment.

4.3.5 The aims of the Living Longer, Living Better programme are entirely consistent with the aims of NMINC and we are able to build on the integrated health and care teams in proactively working with those at risk people and embedding supported self care.

4.4 Palliative and End of Life Care development

4.4.1 Development of the full new delivery model for Care at the End of Life will allow us to build on the work that has already taken place to enable people to die in their place of choice. The need for change to how care is currently delivered for our population is known and illustrated below in the comparisons of place of death.



4.4.2 An End of Life and Palliative Care Development Group has been leading this work so far and their work forms a strong platform from which the full new delivery model can be developed. The group currently comprises hospital, community, voluntary/third sector providers and commissioners.

4.4.3 Work to date has included analysis of baseline data to help predict the number of patients expected to be on palliative care registers in order to inform the expected changes in service requirements over forthcoming years. This work has provided greater understanding of those changes to the current service model which would make a difference to enable people to die in their place of choice.

4.4.4 The work of the group has also included scoping of 'best practice' models and impact analysis for usefulness locally.

4.5 Adults with Complex Needs

4.5.1 A service for homeless people attending the Manchester Royal Infirmary went live in June 2013. The service identifies homeless people who attend the hospital and a dedicated team provides holistic assessment and case management from within the service to ensure integrated hospital, community and primary health and care interventions are specific to their needs. The team are looking at increasing the focus of the outreach aspect of the service so that initial assessments can also be carried out in the community. There are strong links with the general practice surgery in North Manchester providing primary care.

4.5.2 A pilot providing leg ulcer services for those who are homeless is underway and this will be evaluated for its effectiveness in meeting the needs of this population group.

4.5.3 We are able to draw form services such as these as we develop full delivery models to enable those who are homeless and/or have complex needs to access appropriate care

4.6 Children in their early years

4.6.1 There is a citywide phased implementation of the Manchester delivery model and the integrated assessment pathway. This involves midwives, health visitors and early year's workers. One of the first three early implementer sites is in the Charlestown area of North Manchester.

4.6.1 Whilst the design leadership for the full new delivery model is the Central Manchester provider partnership, North provider partnership will ensure its full engagement.

4.7 Intermediate Care development

4.7.1 Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary hospital admission and premature admission to long term residential care and support timely discharge.

4.7.2 Pennine Acute Hospital Trust currently commissions the intermediate care service from Community Integrated Care, an independent provider and Salford Catholic Diocese who own the building the service is provided from. The Trust provides directly any associated Nursing and Allied Health Professional care interventions required. The service is a 15 bedded facility located within the community focussed on the enablement and assessment of predominately older people operating as a step up and step down facility. The fundamental aim of the service is to promote independence and a social model of rehabilitation.

4.7.3 There is also an integrated Intermediate care in the community (home based scheme) team. This team also supports up to 25 people in the community. The intermediate care service works in partnership with the Re-ablement service and is also able to commission in certain circumstances with local independent providers.

4.7.4 The North Manchester Health and Social Care Community Clinical Board work programme includes a review of the needs for intermediate care provision in North Manchester. This will inform a revised and improved service model. Partners and stakeholders are currently analysing data from the National Audit for Intermediate Care in order to benchmark the current services. In addition to scoping areas of good practice nationally and locally work will follow to begin defining options for new intermediate care delivery models.

4.7.5 This work is closely aligned to the development of the new delivery model for Frail Older People and Older People with Dementia.

4.8 Crisis Community Response

4.8.1 Crisis response is an intervention in response to a health or social care crisis that allows a person to be supported and treated at home safely and avoids an unnecessary admission to hospital or residential care. It seeks to maintain and/or help the person regain their maximum independence and to support carers, as a crisis can threaten the stability of care and support arrangements.

4.8.2 An integrated pilot is underway in North Manchester. A team of both health and social care professionals ensures that tailored interventions are offered to people to enhance their quality of life and prevent inappropriate, unplanned admissions.

4.8.3 The team comprises of the following:

- Advanced Practitioner
- Social Worker
- Nurses
- Occupational Therapist
- Physiotherapist
- Support Workers
- Clerical Support
- Pharmacist (planned)

4.8.4 The pilot service offers:

- Initial assessment within 1 hour for urgent referral, up to 3 hours other referrals (9am -8pm), seven days per week including bank holidays.
- Specialist holistic individualised patient assessment, to identify all care needs, comprehensive care planning, implementation and evaluation of care
- Provision of urgent equipment
- Home Care Support, personal care, night sitting services.
- The service will support a wide range of acute and chronic conditions.
- Onward referral to other core services at 72 hours.
- Access to out of Hours GP support
- Medication review (planned)

4.8.5 The service is provided from 9.00am until 20.00 hours, seven days per week. A full evaluation will take place. The findings will be valuable as we take forward development and implementation of Living Longer, Living Better new delivery models.

4.9 Navigator Service

4.9.1 The multidisciplinary health and social care team is successfully establishing a single integrated pathway of care for those people who are medically fit for discharge from the medical assessment unit and accident and emergency department. They ensure timely access to responsive community health and social care to avoid unnecessary stays in hospital.

4.9.2 The team work with frail and vulnerable people to prevent admission and enable integrated care to be delivered outside of hospital. Their work across the health and care system and delivering an improved health and care experience for people will be valuable in forming new delivery models.

5.0 New Delivery Models

5.0.1 Building on the progress made in enhancing our provider partnerships and the demonstrable improvements to date we believe we are well placed to work together towards agreed new delivery models that can provide a coordinated response to achieving improved care outcomes in North Manchester and the vision .

5.0.2 Our next important steps will to build on these new relationships amongst providers and use their collective knowledge and expertise in further designing the new delivery models for the agreed prioritised care groups. We will build on the approach taken and the successful design workshop looking at the Frail Older People and People with Dementia new delivery model. The provider partnership forum, with authority from the North Manchester Health and Social Care Community Clinical Board, will ensure timely and accountable development of new delivery models and local implementation of the programme as a whole.

5.0.3 We believe the above activities and our collaboration to date provide a strong platform for this and we have an agreed approach for taking this forward.

5.0.4 We recognise the underpinning works to be undertaken in areas such as workforce, information and estates for new delivery models to be sustainably delivered which will form part of, subject to all appropriate approvals, implementation plans. Additionally we recognise the work required and outlined below in ensuring appropriate account is taken of the financial and contractual elements of the development.

6.0 Finance and contracting work-stream for the development of the New Delivery Models

6.0.1 To support the financial assessment of the new delivery models being developed under the Living Longer, Living Better (LLLB) programme, a finance and contracting work-stream has been established with representation from all eight partner organisations across Manchester.

6.0.2 From December 2013 to March 2014, the work stream will focus upon:

- **Financial context and goal setting**: agreeing commissioners' affordability and cost envelope - based on the agreed scope of services, current spending baselines, assumptions about investments, stretching efficiency goals, phasing of implementation and a shared understanding of transitional support costs.

- **Stakeholder engagement and governance**: shared financial planning methodologies and assumptions across the eight partners, linked closely with the LLLB programme to ensure appropriate governance.

- **Financial modelling and business case development (Cost Benefit Analysis):** testing the desired impact of care models in the context of the LLLB financial model to understand the cost implications of changes in demand and service provision. This is a crucial step in terms of developing the business cases that will be required to secure investment in 2014/15 and beyond as integration plans expand across wider population groups. The costs of new delivery models must be affordable within the financial context.

- **Contract development**: exploring the scope, risks, benefits and pace of implementation for alternative models of contracting to reflect the new delivery models

- **Better Care Fund**: describing and agreeing the financial implications of the LLLB programme and its impact upon partners, in particular, the acute sector, within the Better Care Fund plan (including agreeing performance baselines against the four national measures that are linked to payment).

An Integrated End of Life (EoL) New Delivery Model Design for Central Manchester

An integrated End of Life (EoL) New Delivery Model Design for Central Manchester

Author:
Sara Radcliffe: Programme Director for Integrating Care, CMFT, and member of the City Wide Leadership Team for Living Longer Living Better (LLLB).

Version 6 of the Document agreed by Central Manchester Provider Partnership Board on 20th December 2013.

Name	Organisation
Gill Heaton	CMFT
Dave Williams	Manchester Carers Forum
David Beckett	Go to Doc
Diane Eaton	Manchester City Council
Ed Dyson	Central Manchester CCG
Ivan Benett	Central Manchester CCG
Jon Simpson	CMFT
Mark Edwards	CMFT
Mike Wild	MACC
Neil Walbran	Health Watch Manchester
Sara Radcliffe	CMFT
David Ratcliffe	NWAS
Stuart Hatton	Manchester Mental Health and Social Care Trust
Vish Mehra	Central Manchester GPPO

Living Longer Living Better – New Delivery Model Design Central Manchester

Executive Summary

This document has been written as a result of people from 12 organisations working together over a two month period, to create a high level design for the a new delivery model for people who are at the end of their life in Central Manchester.

It is a response to Manchester's Living Longer Living Better Integrated Care Programme and has been directed by the emerging commissioner care model and profiles.

We have taken at the heart of the design the premise that Mrs Pankhurst, her carer, her family and the community she lives in are the main focal point. That any design we deliver should be achieved through partnership and have a changed focus to how we deliver care in the community.
We have broken our design into five components which we believe make up a new delivery model.

- **Coproduction** with patients, carers and the community. A model designed with the people and communities that will use it.
- **Coordination** A central service point providing an overview and point of contact for all services in the design, to enable the model to be delivered across multiple providers.
- **Generic teams in each locality** that can care for a person throughout the last year of life regardless of where they live in Central Manchester, their own home or a care home. The teams are known and consistent
- **Specialist team from one hub,** a joined up multi-agency team that will be able to give care to a patient and their carers in the final months of life regardless of where they are living
- **Carer Support** - A physical and virtual service giving advice and information through the last year of life and to carers and families before and after the patient has died. When we refer to carers in the document we are referring to unpaid carers.

Our new delivery model is built upon the work that Central Manchester has been undertaking over the last three years under the framework of the Central Integrated Care Board and other partnership initiatives that have developed. However, we feel that if we are to achieve the outcomes of the care model we need to increase the scale and pace of change whilst eliminating duplication.

For the coming year we have listed actions from April including; the development of the co-production approach, co-ordination centre, generic teams and a single specialist team which would have a hospice at home service.

We also recognise that any new delivery model will need to have a secure governance framework and infrastructure surrounding it This would include areas such as finance and contracting, estates, information and workforce development. All of which will need to be programme managed through a complex and challenging environment.

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Section 1 - Context

1.1 Introduction

1.1.2 The paper describes the new delivery model design for adults at the end of life (aged 18+), who are registered with a GP in Central Manchester, and their carers. It has been produced by a number of providers working together in Central Manchester and is a response to the Manchester Commissioners (3 Clinical Commissioning Groups and Manchester City Council) Living Longer Living Better (LLLB) care model for end of life.

1.1.3 We understand that this is not a final product but is the start of a process by which we, the Central Manchester system, can work together to achieve a vision of care for 2020. A vision which is a coordinated response to a patient and carer's need and is delivered as close to their home as possible.

1.1.4 It is recognised that this is an ambitious programme of work and we understand that there is still a great amount of work to be done in terms of quantifying what this means - resources and activity. We also acknowledge the complexity for the commissioners, the need to be able to work with providers differently in order to commission this model of care, over the next 7 years, to achieve the 2020 vision.

1.1.5 We also understand that there is a large amount of work to be undertaken in areas such as workforce, estates and information. This is needed if the model is to be underpinned and delivered in the community in an effective and sustainable manner.

1.1.6 However, we do believe that what we have outlined is the start of a new delivery model design that can achieve lasting change.

1.2 Design Process and Need for Change

1.2.1 Over the last seven weeks there have been 2 workshops and three design meetings with individuals from a range of organisations who provide services to Central Manchester patients, who are at the end of their lives, and their carers. The people who have been involved are outlined in appendix 1.

1.2.2 This document has been developed from these meetings and workshops. It is our first iteration for what we hope will be an ongoing process of improvement and design to create a new delivery model which will achieve the care model for Central Manchester's population. We also believe that this new delivery model should be seen as a part of a wider system change that includes people with long term conditions and frail older people who may, and adults with dementia.

1.2.3 Most people do not define themselves by a medical label and many have more than one condition, therefore we need to see all the new delivery models as being around the person and therefore sharing many design elements.

1.2.4 A customer and patient engagement event was held in December to engage patients their families and carers around the key themes in the care model.

1.2.5 Over 63 people attended and out of them 45 would like to continue to be engaged in how we go forward. The event was based around asking questions on the present and future care model and some specific issues are contained in the later section on co production.

Section 2 – Commissioning Profile

2.1 This design is a response to the Living Longer Living Better End of Life Care Model produced by Manchester Commissioners. The care model describes the offer, outcomes, measures and standards for this population group.

Living Longer Living Better – adults/children at the end of life

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/parent, professionals own, understand and can jointly and coherently deliver upon 24/7/365 with the flexibility to change the plan when needed.
- Confident and well skilled person and carer to deliver upon self care.
- Carers' wellbeing is maintained during and after the end of life of the person.
- Independence, comfort and wellbeing optimised during the end of life period adhering to the patient/families wishes.
- Can demonstrate it is responsive to the needs of those in protected characteristic groups.
- Costs of the care model To be completed as part of CBA

Measures for Success

The aims of the plan are met

Number of people who die in their place of choice

Patient feedback of care planning

Carer feedback of delivery of the care plan

Health and wellbeing of the carer

Delivered within budget

What will be different for residents of Manchester

I will be informed when it is expected 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 care support 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

The care plan and patient information are accessible by the professionals who will care for them.

Effective multi-disciplinary working.

A focus upon caring and compassion.

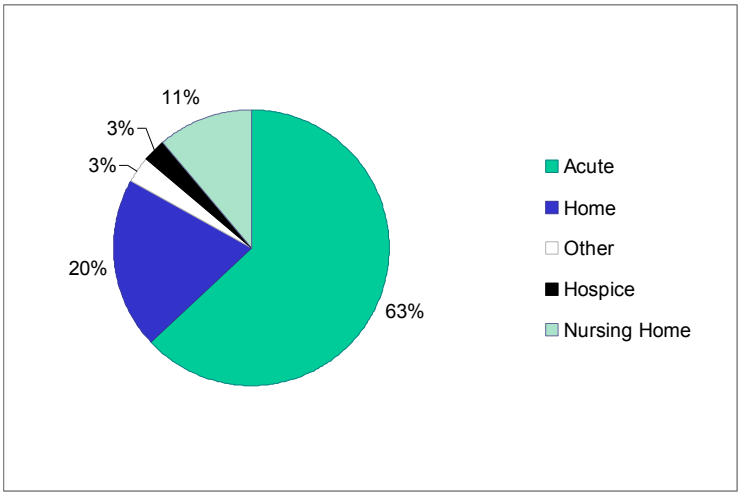
Effective organisational working to avoid gaps or duplication.

A recognition that everyone is different and plans can reflect that.

Standards are high regardless of age, gender, race etc.

2.1.2 The National End of Life Care Intelligence Network showed that in 2005-2007 most people in England died in hospital and according to the National Audit Office (201140% people dying in hospital have no medical need to be there and 59% of people state they are frightened of dying in hospital.)

2.2.2 In Manchester significantly higher than average deaths take place in hospital, an average number of deaths take place at home and below average deaths take place in residential or hospice care.



2.2.3 This table shows the current Manchester numbers by place of death and what the change would be if we were at the national average. Central Manchester level data would be required to calculate it but as a first consideration around 100-140 people's death changing place would bring Central to the national average as an estimate.

	Manchester % Current	England Av %	PCT absolute current	If Manchester was at average	Manchester Change in activity
Home	20%	20%	774	774	**-**
Hospice	3%	5%	124	195	***71***
Care homes	11%	18%	416	679	***263***
Hospital	63%	55%	2,402	2,075	***(327)***

The table below shows those deaths of Patients in Central Manchester CCG.

Place of Death	Total deaths 2010-12	Average annual deaths 2010-12	Percentage of all deaths
Care home (nursing or residential)	380	127	***12.5%***
Home	680	227	***22.3%***
Hospice	101	34	***3.3%***
Hospital (acute or community, not	1812	604	***59.5%***

psychiatric)			
Other Places	72	24	***2.4%***

2.2.4 An initial commissioner view is that it is important to have the key measure of success as people dying in place of choice rather than deaths outside of hospital. This is difficult to measure without first recording everyone's preference, so often number dying out of hospital is used as a measure as this is an indication of the desire of most but not all people.

2.2.5 The commissioners feel practically increasing the number of people who die out of hospital would be the measure in the short term whilst there is a system for measuring place of choice put more effectively in place. There would, however, need to be an assurance measure to ensure that people weren't being moved to out of hospital settings contrary to their choice.

2.2.6 It is expected that in the next 12 months the EPAACS work in Central CCG will be completed thereby giving all agencies a tool by which to share data and care plans and to record end of life place of choice. Increasing the number of people dying in residential or hospice care would therefore be a shared goal which our new delivery model will try to address.

2.3 Commissioning Shift

2.3.1 The following are a series of first draft diagrams produced by the commissioners to look at shift. Further refinement of the tables will continue but this is a good starting point by which the new delivery model can start to be designed.

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Care at End of Life

Impact on other parts of the system i.e. MH, LD, CHC *(for city wide team to complete)*	Needs a further iteration to be split by North, Central and South as may have different baselines. Increased classification of people to end of life will apportion costs to the EoL cohort from other areas (most likely LTC and frail elderly)
Clinical Rationale	Place of choice is for two reasons. 81% of people in the 'Voices' survey had a preference to die outside of hospital. Therefore this is not the choice of all. The target is lower than this in the first instance as the feasibility of this is not yet assessed for clinical conditions or how many deaths can be considered 'expected' in sufficient time to plan for them. Ambitious targets because they have to be but also acknowldges that the England average is seen as below what can be achieved. Pain management is considered a key indicator within the voices service and also a balancing metric to dying at home as this has poorer outcome measures typically than in hospital or in hospice care. Carer experience is the best measure of the end to end pathway from the patient perspective and is a measure within the NHS outcomes framework. but also their experience throughout the process and their wellbeing.
Impact from a GM Perspective	<INSERT IMPACT>

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NHS CHC & Personalised Care

Impact on other parts of the system i.e. MH, LD, CHC *(for city wide team to complete)*	1. Access to primary care for the population groups will include: • All people with complex care needs • Mental health needs • Continuing Healthcare (CHC) • Learning Disabilities (LD) • Chronic Disease Pathways 2. Access to social care and housing options including equipment 3. Brokerage support for the delivery of PHBs 4. Accountancy services for the delivery of PHBs
Clinical Rationale	Health and social care services working together to provide better support at home and earlier treatment in a community setting prevented 2,000 fewer patient s needing emergency care in hospital or a care home The personal health budget pilot evaluation was published in November 2012. The national evaluation found that personal health budgets improved people's quality of life and reflected the local findings in Manchester. The findings showed that: •the amount of times people had to attend hospital decreased overall People had a significant improvement in their care –related quality of life and psychological wellbeing .The health 'status' stayed the same •Benefits where more marked where people had higher levels of need •Personal health budgets also worked better where people were given more choice and control, both over what they bought and how they received the budget .In contrast where the pilot site imposed a lot of restrictions, personal health budgets tended to worsen peoples outcomes •People reported positive impacts of their personal health budgets for themselves and for their family members •They also talked about the change in their relationship with health professionals •Family careers were more likely to report a better quality of life and perceived health than careers of people in the control group •if half of the people eligible for NHS Continuing Healthcare chose to take the offer of a budget, this could imply a potential saving of around £90 million
Impact from a GM Perspective	Economies of scale across GM for services such as brokerage, equipment and accountancy services

2.3.2 The commissioners have outlined initial objectives and targets which are listed below. In the workshops and design team meetings we have accepted that these objectives and targets are a good starting point, but we will need to

have more discussion to ascertain what this will mean in terms of how, timescale, resource and measurement etc.

2.4 End of life Objectives and Targets

2.4.1 The objective is for patients to die in a place of their choice. The target is 70% by 2016/17. This assumes for the time being that patients would choose to die out of hospital. However, it should be acknowledged this figure is consistent with national survey findings of patients' preferred place of death.

2.4.2 The objective is for deaths to take place out of hospitals. The targets are 38% for 2013/14, rising to 41% in 2014/15. We should match the current England average of 46% in 2015/16, and achieve 52% in 2016/17. In 2017/18 we should be level with England's current best (58%), and the target for 2018/19 is 63%.

2.4.3 The aim is for patient/carer experience to be tested through the CCG Patient Public Advisory Group. Assessment of method and therefore improvement metric are currently unknown. The measures: are patient experience of care planning; pain management; and carer experience/carer's view on the quality of care over the final 12 months.

2.4.4 The goal is an improved number of care plans, including a recorded choice of preferred place of death. The targets are 1600 deaths in 2013/14, 1900 in 2014/15 and 2200 in 2015/16. In 2016/17 the target is for 70% (around 2500) of all deaths to have had care plans. This is also the year when we will make an assessment of how many deaths are predictable. In 2017/18, 80% of all predictable deaths should have an end of life care plan. This figure should be 90% in 2018/19.

2.4.5 The objective is for professional team working assessments (as recorded by Integrated Team Monitoring Assessment Tool; or similar) to show high levels of agreement. The timescale is to have over 90% 'agree' in 2016/17, and over 75% 'strongly agree' in the same year. These should then be maintained in the next two years. This will be achieved by setting a baseline target in 2013/14, and setting an interim target in 2014/15 (to be reached by 2015/16).

2.4.6 The goal is regarding finance. In 2013/14, the CBA will be used as a baseline. In the years after that, we aim to shift the place of death in line with the targets mentioned above (e.g. 38% out of hospitals in 2013/14, 41% the year after etc.) at a cost of 2/3rds of the average admission and investment consumed within the financial year.

2.4.7 From an equality point of view, we will establish a baseline in 2013/14. In the succeeding years, outcome measures should be consistent across specified protected groups who are commonly diagnosed with mental health issues and dementia.

2.5 CHC and Personalised Care Objectives and Targets

2.5.1 Anyone who is eligible for NHS CHC will be offered a personal care plan by 2014/15. In 2013/14 we hope to offer care plans to 75% of such patients. Eligible patients include anyone with complex or continuing care needs,

mental health patients and those with learning disabilities, and those with chronic diseases.

2.5.2 The same people should be made aware of their right to a personal health budget. Again we aim to tell 75% of patients in 2013/14 and 100% in 2014/15.

2.5.3 The same numbers apply to the idea that everyone should only have to tell their story once. This will help to tackle issues at an earlier stage, rather than relying on the more expensive crisis services. This is particularly relevant for older people with long term conditions and families with complex needs.

2.5.4 We aim to put patients at the heart of care. This will be measure by the new NICE Quality standard. Providers will introduce the 'friends and family' test, as well as patient shadowing, in order to judge user experience.

2.5.5 Patients will also be offered the right to 'diarise' their journey, giving them more information and more control of their care. The targets are 85% in 2013/14, rising to 90% the year after and 100% in 2015/16.

2.5.6 Patient choice is an important goal of ours. We want 100% of patients to be able to choose the date and time of their appointments, as well as choosing their provider, site and specialist. This is to be completed by 2014/15.

2.5.7 We also want assessments to include support on self-management in primary and secondary care for a range of long term conditions. The plans should be established and reviewed in 2014, and introduced in 2015.

2.6 Financial profiling

2.6.1 To support the financial assessment of the new delivery models being developed under the LLLB programme, a finance and contracting work-stream has been established with representation from all eight partner organisations across Manchester. From December 2013 to March 2014, the workstream will focus upon:

2.6.2 **Financial context and goal setting**: agreeing commissioners' affordability and cost envelope - based on the agreed scope of services, current spending baselines, assumptions about investments, stretching efficiency goals, phasing of implementation and a shared understanding of transitional support costs.

2.6.3 **Stakeholder engagement and governance**: shared financial planning methodologies and assumptions across the eight partners, linked closely with the LLLB programme to ensure appropriate governance.

2.6.4 **Financial modelling and business case development (Cost Benefit Analysis):** testing the desired impact of care models in the context of the LLLB financial model to understand the cost implications of changes in demand and service provision. This is a crucial step in terms of developing the business cases that will be required to secure investment in 2014/15 and

beyond as integration plans expand across wider population groups. The costs of new delivery models must be affordable within the financial context.

2.6.5 **Contract development:** exploring the scope, risks, benefits and pace of implementation for alternative models of contracting to reflect the new delivery models.

2.6.6 **Better Care Fund:** describing and agreeing the financial implications of the LLLB programme and its impact upon partners, in particular, the acute sector, within the Better Care Fund plan (including agreeing performance baselines against the four national measures that are linked to payment).

2.7 Pre Alliance Contract

2.7.1 In addition to the cost benefit analysis work partners in Central Manchester's health and social care system are working to develop an Alliance contract around urgent care services. The aim of this is to align goals between providers and commissioners, to collectively reward achievement of goals and to support a movement of resource to increase out of hospital care. The full alliance will commence in 2015 but a pre-alliance contract is planned for 2014 which will incorporate these same aims.

2.7.2 The relevance to the implementation of new delivery models is in two parts.

1. The pre-alliance will have a performance related pay framework which includes both implementation of New Delivery Model and achievement of outcome measures.
2. The pre-alliance plans to have the means by which money can move within the overall contract to support investment planning.

2.7.3 These are designed to support and enable the development and resourcing of New Delivery Models for LLLB. Organisations are now working together to put in places this contract arrangement for April 2014.

2.8 Provider Response to the Commissioning Profiles

2.8.1 As a group of providers we have considered the commissioning profiles as they currently exist. We believe we can work together to produce a joined up, co-ordinated design which we believe will achieve the outcomes, benefits and standards as identified above.

2.8.2 However there are issues that need to be considered:

2.8.3 We will need to explore in more detail the objectives and targets to ensure that they are understood by providers and we can be confident not only of delivering them but them being understood and measured.

2.8.4 We are aware that changing services cannot be achieved overnight and there needs to be a period of development, evaluation and shift to enable

sustainability. Therefore the timeline in which the new delivery model is implemented is crucial and will need to be phased in and delivered over a number of years to achieve the full model.

2.8.5 There is the issue of understanding the current resource envelope for this care model across providers, and any future resource envelope that we need to work within. Without this information the new delivery model we have put forward is un-costed. Therefore it will need to be reassessed in the light of the work of the financial workstream outlined above.

2.8.6 Many of the providers in the new delivery design, but not all, are part of the pre alliance contract work. This poses an issue as to how we will ensure that all providers that are within a new delivery model are working to the same contractual framework as those in the pre alliance contract.

2.8.7 There is also the issue that the new delivery models will by their nature cross many providers and therefore there is the issue of the providers understanding and agreeing the joint targets and objectives that they will need to achieve together.

2.8.8 We also feel that there are significant implications for the new delivery models in relation to the Care and Support Bill.

2.8.9 The Care and Support Bill aims to prevent and reduce needs, put people in control of their own care and clarify entitlements to care and support. The bill will come into effect from April 2014 and will be fully implemented in Manchester by April 2015.

2.8.10 From April 2013, the local authority will be responsible for using national minimum eligibility criteria to identify any people who have an unmet care need, completing initial assessments to establish whether people are eligible for care, completing financial assessments to determine who will pay for the care and providing personalised care and support plans to people and carers where required. The bill also gives legal entitlement for an individual to receive a personal budget which outlines the total cost of providing their agreed care plan. These duties will apply to all people irrespective of whether they are funded by the local authority or self-funded.

2.8.11 The bill gives the same rights to carers as those given to the people they care for. Local authorities will have a duty to identify carers with unmet needs and provide them with assessments and support plans.

2.8.12 There are significant financial implications from the bill which will need to be taken into consideration. The financial impact cannot currently be reliably modelled and there is a very high level of uncertainty and risk around the financial implications of the bill and its impact on a new delivery model

Section 3 – Current Provision

3.1.1 In this section we have worked as a collection of organisations to piece together what we view is the current provision profile. This section is at a very high level as we only have the knowledge of the people in the room at the time. Therefore there may be other services that are commissioned, or pilots being undertaken, that we are not aware of, and therefore not outlined.

3.1.2 The Central Manchester system has a strong foundation of integrated working across a range of providers. This is both under the framework of the Central Integrated Care Board and outside it. There has been particular success in the last two years in implementing practice integrated care teams in 25 practices and a range of intermediate care services. These have formed what is labelled the "five year plan" (appendix 2) and much of the design in this document is predicated on these developments underpinning future design.

3.1.3 We are also at a very early stage of working together in a co-production methodology as a provider group. It is comfortable to look at change for the future and acceptable to look at current issues - it is more difficult when we need to share activity, data or financial information which may be sensitive. We have numerous business cases across the organisations for various parts of a potential new delivery model. These are known, but we have not shared them, until we are clear on the process from April to implement parts of the NDM.

3.1.4 There is no hospice geographically located within Manchester. Inpatient and outpatient hospice care is commissioned from St Ann's who are based on two sites - Heald Green, Stockport and Little Hulton, Salford. Neither of these sites are conveniently located for patients and carers resident in Central Manchester.

3.1.5 During the last 12 months of life patients and carers living in Central Manchester will access a range of services from multiple providers, including agency carers. The absence of a co-ordinated hospice at home services potentially places an increased reliance on care provision from private agencies accessed as part of the overall social care package, CHC assessment and/or via individual personal health budgets.

3.1.6 Relationship building and consistency of care providers is an important aspect of end of life care, as a high level of confidence between patients and carers underpins effective delivery of care. In practice there is an overall lack of continuity that may impact negatively on patients as provider agencies are frequently liable to change, often at a crucial time in the patient's journey.

3.1.7 An example of this is when a patient has a rapidly deteriorating condition and may be entering a terminal phase. Fast track assessment for CHC funding will enable needs to be met urgently, thus facilitating patients going home to die by providing appropriate end of life care either in their own home or in a care setting. The care will be commissioned from approved agencies, depending on availability and patient need. . At present MCC and CHC both have lists of approved care agencies. However, some agencies are on one approved list and not the other. If a patient transfers from social care to continuing health care, including fast track process for end of life, there is a possibility that their carers will change, although every effort will be made to facilitate continuity. For patients with an individual budget (IB) for care, a CHC funding award will supersede the IB and the structures are not currently in place automatically transfer any directly purchased personal assistant (PA) sessions. For many individuals their PA will be an important part of their lives

and retaining their PA when they approach the end of their life would be considered a priority.

3.1.8 Caring for and supporting patients approaching the end of their life is considered the most challenging work any health and social care worker faces, and a quality experience for patients and carers will rely upon carers being well trained supported to deliver effective end of life care. At present there is no consistency of quality assurance regarding training of the agency or directly employed personal care workforce commissioned to support patients at the end of their life in Central Manchester.

3.1.9 The table does not provide an exclusive list, but what we as a group see as the present picture in 2013. We have demonstrated the services as those that are core to our future design category A and those that will be impacted by a change in the design category B.

In summary they are:

Category A – e.g. core services to NDM	Category B – e.g. of Impacted services
Secondary Care Services Community health care services Citywide specialist community health services e.g. Learning Disabilities St Ann's Hospice services Macmillan Cancer Support Marie Curie Cancer Care GP practices in Central Manchester GP Provider Organisation Central Manchester GP Provider Organisation Out of hours medical services 'Go to Doc' Manchester Age Concern Mental health Services e.g. Admiral nurses Central Integrated Care Board Projects examples: • End of Life pathway • End of Life IT system (EPaCCS) • Do not attempt Cardio Pulmonary Resuscitation • End of Life Residential Care Homes • Multi-disciplinary Hospice at Home type Model • CMFT IV and subcut fluid pilot (through community nursing) • Practice Integrated Care Teams Manchester City Council Directly delivered e.g. :	A & E Departments A&E – plus walk in centre in-patient wards (adults) Bed management teams Complex discharge service Clinical 'speciality teams' e.g. Renal, Cardiac, Respiratory, Cancers Safeguarding facilities management systems (e.g.. portering) Pharmacy Ambulance and transport Diagnostic services Laboratory services

• Safeguarding Adults Team • Social Work and Primary Assessment Services • Contact Centre • Carers Support • Equipment & Adaptations Service • Re-ablement Commissioned e.g.: Community Support – Voluntary Sector Services Healthy Lifestyles Home based support Support services for mental health Residential Care Homes Nursing Homes Respite Care Private social care agency providers Residential homes located in central Manchester Nursing Homes	

3.2 Current Provision by location

3.2.1 Whilst it was acknowledged that there are existing services providing excellent end of life care it is not formally coordinated and often relies on informal networks and communication systems. The table below gives an overview of care provision at all stages by location during the last year of life in Central Manchester.

3.2.2 This demonstrates the range of services available – specialist palliative care, charitable partnerships, community teams and hospice provision etc and highlights the potential for 'silo' working between providers; thus increasing the risk of duplication, patients telling their story many times and for breakdown in communication.

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Service	CMFT Acute	Intermediate Care - bed base & home care pathway	Care Home	Patient's own home	St Ann's Hospice	Community Setting	Malignant/ Non-malignant disease
Consultant in Palliative Medicine	0.5 WTE	No – consultant in elderly medicine	No	No	Yes	No provision	Both
Macmillan specialist Therapy SLT, OT, Dietician	Yes	No – generic therapy as part of multidisciplinary team	No	No Generic AHP	Yes	Very limited provision from PAT	Both. Cancer 80% Non-cancer 20%
Macmillan specialist palliative care nursing	Yes	In reach	Community Macmillan team	Community Macmillan team	Yes	Community Macmillan team	Both. Cancer 80% Non-cancer 20%
EoL facilitator	Yes	No	Limited	No	No	EoL facilitator working with primary care	Both
Acute oncology	Yes	No	No	No	No	No provision	Cancer only
Generic nursing/medical teams	Ward/department based	Yes Homecare pathway ICAT Bed base	Nursing Home Support Team	Marie Curie planned care service – nights (home and residneital homes)	Yes	District nurses Practice nurse Active case managers	Both
Specialist nurses e.g. heart failure, diabetes	Specialist in-patient & clinic care	Community IV therapy	No	No	No	GP/practice nurse. No specialist nurse outreach	Non-cancer
Discharge services	Yes	Funded nursing care team	Yes	Funded nursing care team	Yes	Funded nursing care team	Both
Chaplaincy and Spiritual Services	Yes	No chaplaincy outreach	No chaplaincy outreach	No chaplaincy outreach	Yes	Patient/carer's local networks	Both
Bereavement Services	Yes bereavement centre	No	No	No	Yes (known to service)	Macmillan Solutions Mental health services GP CRUSE	Both
Social Care	No	Yes – homecare pathway/rapid response	No	Yes	Social Worker	Yes	Both
Hospice specialist palliative care services	No	No	No	Complementary therapies at home only	Yes – in patient/outpatient/day care	Neil Cliffe Centre (Wythenshawe) St Ann's 24 hour advice line	Both

3.3 Central Manchester CCG Demonstrator Site

3.3.1 In 2013, Central Manchester CCG successfully secured a Demonstrator Community Site bid which crosses all GP practices in Central Manchester. The expectation from the Greater Manchester Area Team is that projects will be able to show demonstrable outcomes and benefits by April 2014. It is important that any new delivery model in Central Manchester takes into account the demonstrator site's projects and the possibilities of integration rather than duplication for future sustainability.

3.3.2 A summary of the projects is listed in the table below:

Domain	Project	Rationale/model
Access *Improved access through collaborative working across practices extending availability and responsiveness.*	**Responsive Access**	Practices to adhere to quality standards of responsiveness to patient urgent and same day need.
	Primary care availability	Increase primary care available hours – to 8pm weekdays and 3 hours per day weekends, total 16 pw, through collaborative local arrangements.
	Primary care Homeless access	Specialist primary care through services at individual practices; potentially ensuring CCG wide co-ordination through GPPO.
Long term conditions *Improved Care through ensuring access to enhanced primary care services.*	**Long term conditions – Diabetes/HF**	To ensure population coverage of existing enhanced services for Heart failure and Diabetes.
	Patient education for people with LTC	Inhaler technique project through community pharmacy.
Patient Voice *Improving engagement and involvement of patients in their own care.*	**Dementia**	Population coverage for enhanced care for patients with Dementia
	Care Homes	Enhanced primary care medical and nursing services for patients in residential care and nursing homes.
Specialist primary care *Closing the gap between primary and secondary care through improving specialist primary care services.*	**Persistent pain management service**	Pilot service for patients who experience persistent pain lasting longer than 3 months. Commissioned from specialist acute provider, delivered through specialist primary care service.
	GP led in-reach	Provide additional medical input to patients admitted to CMFT, to support timely discharge and coordinated care in the community. Initially pilot practice, possible roll out following evaluation.
	Access to specialist consultant advice	Increase the number of routine Specialist Consultant Advice lines with main local acute provider, CMFT.

3.4 Summary of Issues with the Current Provision

3.4.1 The initial mapping of the current services has raised specific issues that will need to be addressed as we develop a new delivery model:

- The services and projects are currently fragmented across service and organisational boundaries - care pathways do not support moving a patient quickly to their place of choice i.e. outreach from the acute sector or rapid care into patients' homes.
- There is no single point of access for patients/carers or practitioners to navigate the many services currently available. Therefore care becomes difficult to understand, what's available and how to access it.
- The services are not seven day or 24 hour across the range provided and because of fragmentation there is no understanding of how a 24/7 service could be co-ordinated and provided.
- Continuity of care is variable, currently key workers changes between care settings rather than a person having the key worker that knows them best, regardless of where care is being delivered.
- There is no community consultant in palliative medicine to provide specialist medical assessment outside of the hospital or a hospice setting. The consultant cover is very limited to one individual based within acute and hospice settings only.
- The specialist palliative care service in Monday to Friday only and therefore cannot provide face to face assessments, crisis response or co ordination for people to be able to be cared for in their place of choice.
- There is limited rehabilitative provision at home and very little therapeutic support e.g. occupational therapy, Speech and Language Therapy, Physiotherapy and Dietetics. Specialist therapy is provided in the hospice setting, however travelling to Stockport or Salford remains an issue.
- There is minimal bereavement support in the community and the hospital service is weekdays only.
- There is a lack of understanding about how we care for people in the beds available across peoples' homes, care homes and hospital if they so wish, and whether an increase in beds is needed.
- There is no community developed model to foster a volunteer workforce and use the potential we have in areas such as CMFT volunteers' service.
- There is limited facility for out of hours access to diagnostics, equipment commissioning micro packages of care.
- Allocation of different carers at the end of life due to funding arrangements.

3.5 Different Models

3.5.1 There are many different delivery models across the UK, in response to local need. In neighbouring areas there are examples of hospice at home services which are listed below:

- Salford and Trafford - hospice at home service based at St Ann's hospice. The service contributes to the provision of End of Life Care for all patients based on need not diagnosis. It is a comprehensive and equitable hospice at home service for palliative and end of life patients

across Salford and Trafford on a 9-5pm, 7days a week basis, 365 days a year. It will assess, plan and provide a service to all patients with end of life care needs including crisis intervention, the delivery of hands on care and to facilitate rapid discharge from hospital/hospice. It aims to support patients in achieving their preferred place of care/death.

- Rochdale - hospice at home service provided by Springhill hospice. 365 day per year health and personal care provided by a combination of registered nurses and health care assistants. Specialist palliative care provision from hospice & close working with community Macmillan team. District nurse remains key worker.

- Liverpool - urban health economy similar to Manchester. Partnership between Marie Curie and acute hospital trusts to provide a 72 hour supported rapid discharge service at end of life co-ordinated by registered nurses to expedite dying at home. Post 72 hours if, patient is stable then care is transferred to the Marie Curie/Crossroads STAR service based at the hospice. This service provides nursing, health and personal care for up to 3 months at the end of life. This service is commissioned from CHC specialist commissioning services (patients will be eligible for fast track end of life CHC funding). There are funding benefits as Marie Curie match fund investment 50:50.

- North Manchester - 2 year pilot site for Macmillan Manchester project 'Redesigning the System' Midhurst model is in the planning stages. Midhurst is a very different health economy to Manchester. However, economic evaluation has demonstrated significant cost benefits through reduced length of stay and prevention of admission. This is essentially a hospice without walls model that will provide support and intervention at any stage once a patient is diagnosed with a life limiting illness. The service is provided by a multidisciplinary team consisting of palliative care consultants, specialist nurses, health care support workers, allied health professionals and volunteers. Volunteers provide additional support through activities such as shopping or gardening. Information about patients is shared at multidisciplinary meetings held daily and weekly and logged on the internal IT system

Section 4 - The New Delivery Model Design

4.1.1 As providers we totally endorse the need to see the person rather than the patient and to work with, involve and learn from the carer, the family and the community.

4.1.2 We endorse the symbol of Mrs Pankhurst for our new delivery models and the need to look at how the individual is central to all that we do, and their care is defined by their choices and their lives rather than our organisational structures.

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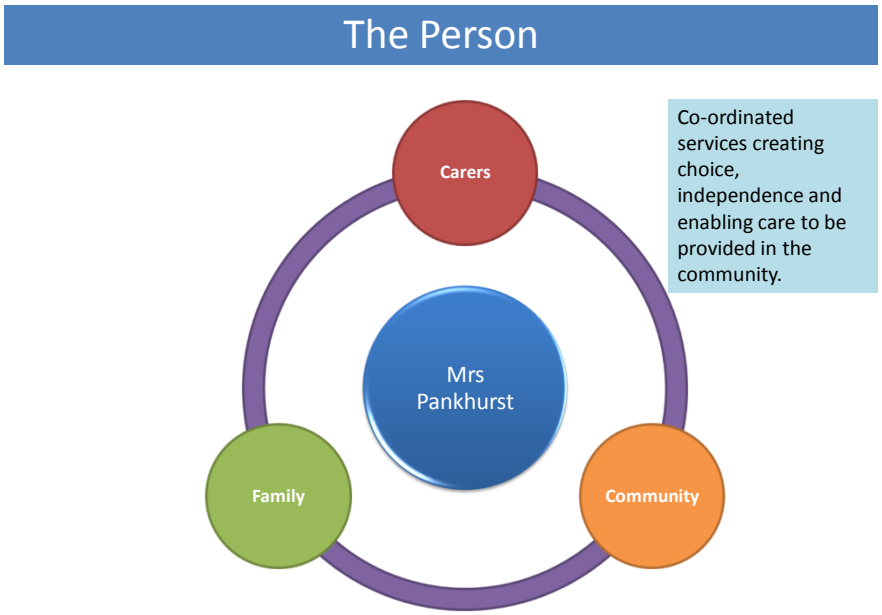


4.2.1 By 2020

4.2.2 In exploring what a new delivery model design would mean for the registered adult population of Central Manchester, and the current providers that deliver services, we have assumed that by 2020 we will need to:

- Achieve the commissioned care model
- Deliver co-ordinated services, across providers, over a two year end of life period
- Deliver a model predominantly in the community

4.2.3 We believe our NDM design will be delivered with

- dignity and respect
- in familiar surroundings
- in the company of close family and/or friends
- coordinated for the patient and carer – no gaps, no hand offs
- provide a comfortable last year of life without pain and other symptoms

4.2.4 We believe our model should be delivered over the last year of life to provide care for the person who is dying and for a year after that person's death to provide care for the carers and family who have been bereaved. This is consistent with the DoH End of Life Care Programme which was issued in 2004.

4.3 The components of our design

4.3.1 We have listed below five design components that we believe would make up our new delivery model. We believe that the new model should provide care wherever a person is in the community be that in their own home, a residential or a care home.

4.3.2 Coproduction with patients, carers and the community. A model designed with the people and communities that will use it.

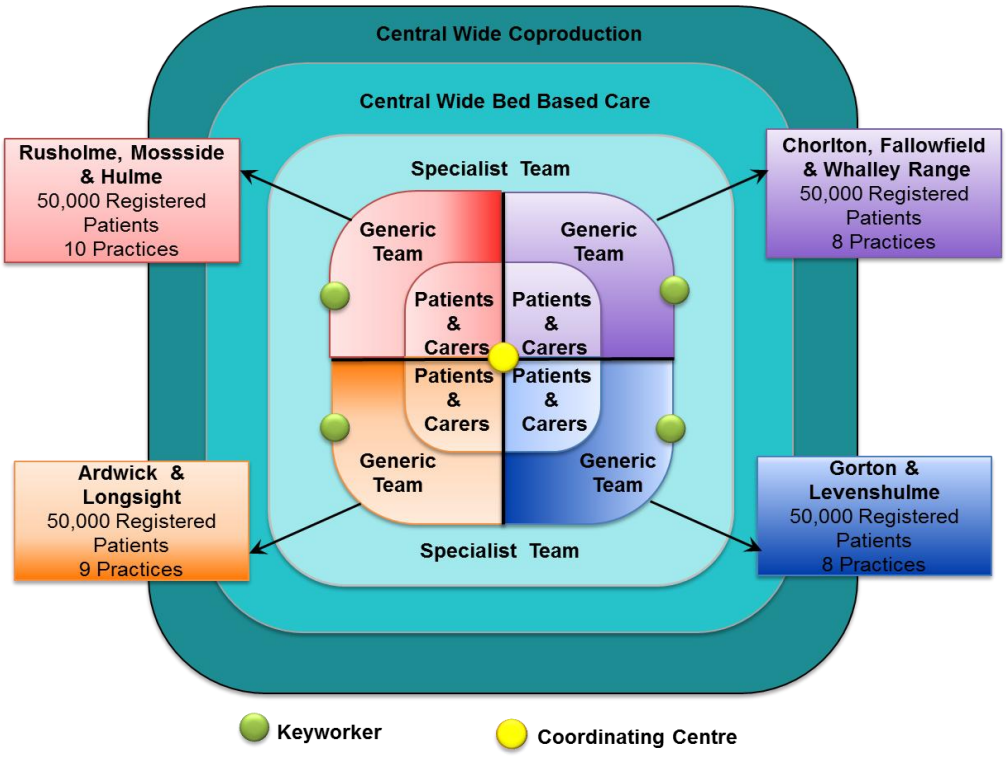
4.3.3 Coordination A central service point providing an overview and point of contact for all services in the design, to enable the model to be delivered across multiple providers.

4.3.4 Generic teams in each locality that can care for a person throughout the last year of life regardless of where they live in Central Manchester, their own home or a care home. The teams are known and consistent.

4.3.5 Specialist team from one hub, a joined up multi agency team that will be able to give care to a patient and their carers in the final months of life regardless of where they are living.

4.3.6 Carer Support - A physical and virtual service giving advice and information through the last year of life and to carers and families before and after the patient has died.

The diagram below pictorially shows the components of our design



4.3.7 As with any ambitious multi agency redesign, if agreed the model will need to be developed with partner organisations and the details of how, where and when worked through to enable pathways, teams, services and ultimately the model to work effectively.

4.3.8 The outlines below are high level descriptions of what we think should be developed.

4.4 Co -production

4.4.1 This design is at a very early stage and we know that what we have in place in 2013 will not be what we will aim for in 2020. However, one of the main areas that we feel we need to address is the ability to work with local communities in a way which enable us to co produce and design models for the future.

4.4.2 We need to create a different culture and design platform where patients, carers and the community are co producing what the 2020 services will be.

4.4.3 We want to build an infrastructure of community volunteer support which is the foundation block of our model design in 2020.

4.4.4 We believe co production should cross all new delivery models in Central Manchester and we would want to work with others to see whether it could be a model for the whole of the city. In designing a new way of working together we would look to address the aspects of co production as outlined by the Social Care Institute for Excellence (2013), Co-production in social care, what it is and how to do it, http://www.scie.org.uk/

4.4.5 Co-production is much more than just going out to consultation or co-creation where service users are involved in design. It is about seeing service users as equal partners with shared power and involving them in design, delivery, decision making and evaluation. To do this properly there will need to be radical changes to culture, structure and practice and this change will need to be accompanied by movement of resources to the people using services and frontline staff.

4.4.6 Coproduction will need to run through the culture of our health and social care partners and a shared understanding about what coproduction is the principles for putting the approach into action and the expected benefits and outcomes will need to be agreed. In order to achieve this change organisations will need to develop a culture of being risk aware rather than risk averse.

4.4.7 The December event was a very first, small step in the process of working together. When asked at the December customer and patient engagement event how well do you think health and social care services work for end of life care now.

- 19% good
- 9% average
- 12% poor

- 21% very poor
- 22% don't know.

4.4.8 When asked after hearing about the new care model what do you think.

- 40% said it would improve things for patients and carers
- 3% said it would not make a difference for patients and carers
- 9% said it would make things worse for patients and carers
- 19% were not sure

4.4.9 Obviously we have a lot more work to do on how we work with patients and carers to co-produce designs and implement appropriately.

4.5 Co-ordination Centre

4.5.1 There will need to be a co ordination function across the new delivery model so that the services are known and understood to patients, carers and practitioners.

4.5.2 This will mean that this function, and therefore the model, can be accessed through a single point of contact – we are assuming this would be a one number gateway.

4.5.3 A single number would provide the caller with a person as the point of access to be able to signpost and navigate the practitioner, patient or carer through the menu of services as required.

4.5.4 We would expect this service to not only be able to give advice but if needed that the service would also be able to micro commission services for the patient, carer or practitioner which are appropriate e.g. this could be rapid access to CHC, access to equipment, access to beds across the community, rapid access to volunteers, medicines or diagnostics.

4.5.5 We realise that this is a highly ambitious idea and we believe it should cross all the new delivery models and in some instances Manchester as a whole if appropriate. We believe that there is no future in organisation's modelling their own gateways which produce numerous single numbers for people with multiple conditions, and if we looked to combine our resources and expertise we could design and provide a highly skilled effective and responsive service.

4.6 Generic teams in each locality

4.6.1 Multi-agency, coordinated generic teams that would deliver care across the last year of a person's life, providing support and care to patients and carers and to carers after the person has died. These teams would also be part of the LTC and Frail older person's new delivery model designs.

4.6.2 We would see these teams as being based around the GP, nursing and social workforce in the community but with other members as needed. We currently have practice integrated care teams in 25 practices in Central Manchester and would aim for the teams to build upon this model. The teams would need to be flexible enough to respond to local need and circumstances in terms of

case loads and skills sets. We would build the team linking into the 24/7 district nurses and social work /care enabling a 24/7 approach.

4.6.3 The team's role as, we see, it would be to identify those people who are at the end of life with practitioners in the specialist team. The team would provide a key worker for each person. The key worker would manage the interface between primary, secondary and social care and the expectations of patients and carers. At certain points it may be more appropriate for the key worker to be in a specialist team, but the generic team key worker would be able to provide a point of reference for consistency.

4.6.4 The teams would work within a framework that would look at all the services and projects to provide high quality end of life care currently in this area and look to eliminate duplication, effectiveness and efficiency across the current services and projects.

4.6.5 Information about the person that is accessible to each service in the NDM, e.g. when a person enters a hospital the appropriate key worker is contacted to co ordinate the end of life care package. This would link into the EPAAC record and the development of the electronic patient record system. A key worker who will provide a care plan early in the journey that can travel with the patient regardless of the setting care is provided in.

4.6.6 The team will be able to access clear referral systems that are linked to the specialist team and have a single shared assessment and plan. Information will be shared across interfaces including Out of Hours and NWAS. There will need to be an understanding of skills and knowledge between the generic and specialist teams to ensure continuity of care across the interface.

4.6.7 The changing role of GPs and the primary care commissioning strategy would be central to the generic team design.

4.7 Specialist Team

4.7.1 The specialist team would bring together many current practitioners and services but also encompass a hospice at home model, which we currently do not have. It would focus on the last 3 months of life and be flexible in terms of providing care, based on individual need as and when required, during the last 12 months of life and into the bereavement period.

4.7.2 It would work in a co-ordinated way across agencies and settings to ensure that patients and carers receive the 'right care at the right time in the right place' with the outcome that patients are supported to live well and die at home.

4.7.3 The specialist team would provide care for patients and their carers with both malignant and non-malignant disease. Macmillan Cancer Support suggests that post holders prioritise patients with a cancer diagnosis but support the delivery of specialist palliative care to all disease groups.

4.7.4 The team would support and enhance the work of the generic teams in each locality. It would aim to achieve an integrated gold standard hospice at home

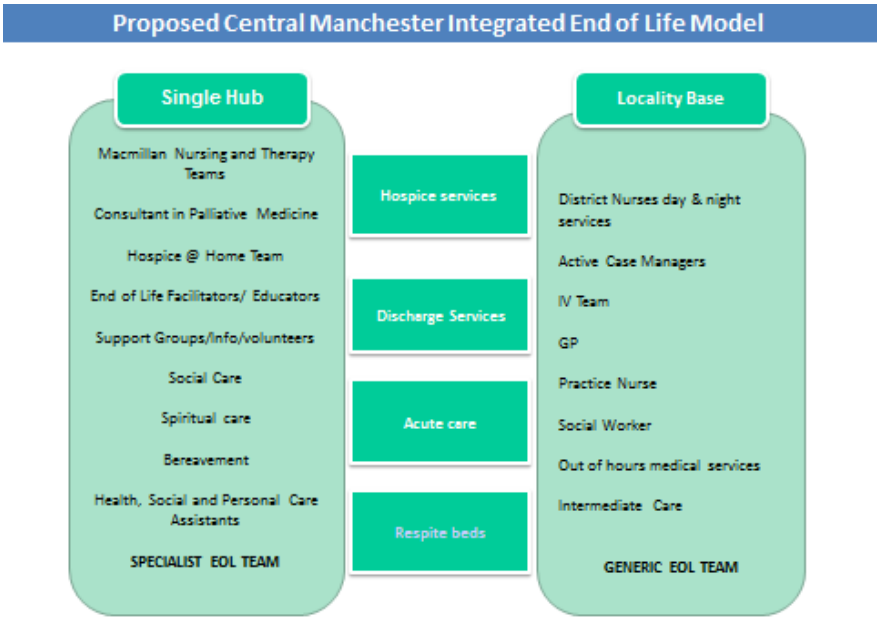
type model that meets the needs of Central Manchester residents during their last months of life.

4.7.5 This team would have a number of practitioners from different organisations that are co-located e.g.:

- Consultant in palliative medicine working across the interface of the hospital and community providing leadership, governance and integrated care
- specialist nursing teams
- specialist therapy teams providing rehabilitation in a person's own home and community settings 72 hour crisis response
- health, social and personal care assistants
- In reach/outreach step up step down to support rapid discharge and prevent admission
- Specialist Social Workers

4.7.6 The team would operate under one framework by which to avoid duplication, and increase effectiveness and efficiency across the current services and projects.

4.7.7 The diagram below outlines in pictorial form examples of who could be in our generic and specialist teams.



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Existing Resource Vs Resource required

Model Components	Existing resource	Additional Resource/change required
Generic Teams	PICT Teams DN 24 hour service Marie Curie planned care	Increased capacity for day & night district nursing Insufficient availability to meet demand
Specialist PC Teams	Acute and community	•Consultant in Palliative Medicine •Existing resource redesign •Specialist therapy •Chaplaincy outreach •7 day Macmillan team working •Outreach by specialist nurses e.g. HF
H@H		•72 hour supported discharge project (Marie Curie partnership) •Planned care uplift •Admin/leadership •Health & personal care assistants

Existing Resource Vs Resource required

Bereavement support	Not easily accessible in the community •Bereavement centre CMFT •Macmillan solutions •Voluntary e.g. CRUSE •GP •Mental health services •St Ann's if known to service	•Model should include robust response to carers needs for bereavement follow up and support for up to one year

Living Longer Living Better – New Delivery Model Design
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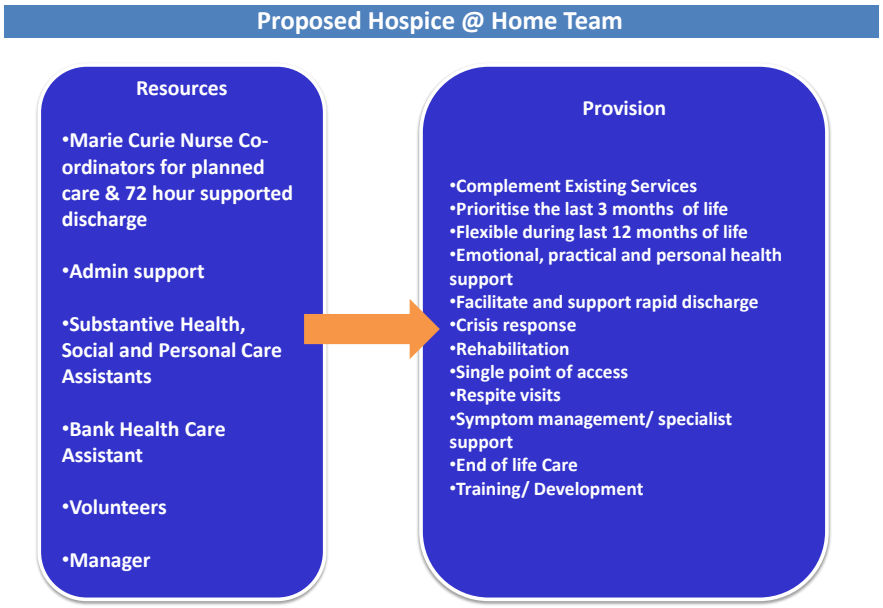


4.8 Carer support

4.8.1 We will need to support carers pre and post the death of a loved one, not only in the delivery of care for a patient but their own wellbeing. We want to be able to support carers to remain in school, working and active in the community before and after the death of their loved one.

4.8.2 To do this we need to be able to know the carer, identify their own needs separate to the patient and be able to plan for their own care and well being. We would want the services to come together to be able to offer this support through identifying the carer and their health and social care needs. We need to enable the carer to be heard, understood and involved, providing practical support such as respite care, bereavement care, patient advocacy, consideration of dependent children and the practicalities of death – wills/legal, housing.

4.8.3 We believe that as a system we currently do not recognise the amount of care that is being provided by carers across our city and the impact on the system if carers were not able to care. We also believe that as a system we have little understanding of the needs of the younger carers in our community and the affect that caring has, not only on their well being but their opportunities and potential. We want our new delivery models to start to address these issues through co production and involving and caring for carers more proactively.

4.9 April 2014 Onwards

4.9.1 The actions listed below are a summary of what we believe we could start to work on from April 14. It is dependent on there being agreement to the initial new delivery model, and the issue of transitional resources being addressed. Therefore, this is a high level view, taken from more detailed work we have

undertaken, which would need to be further developed if the design was accepted.

- **Co-production**

4.9.2 Establish a framework for co-production and design of the new delivery model between 2014-2020 by patients, carers, the community and practitioners. Explore this being shared with other new delivery models in Central and possibly across the city.

- **Co-ordination Centre**

4.9.3 Design for a co ordination centre across all the cohorts in LTC, EoL and frail older people to be drawn up to enable a simple number and response for patients, carers and practitioners to co ordinate a person's care around the system. Explore whether this can be shared wider than central if needed.

4.9.4 The co-ordination centre to facilitate information on and access to all agencies both statutory and non-statutory. Plan for access to information for service providers, patients, families and carers.

4.9.5 Co-ordinators in centre to develop access pathways to all services to facilitate ease of navigation through services and to monitor gaps in provision.

4.9.6 Improved more efficient way of micro commissioning of packages of care and access to equipment, diagnostics etc to avoid duplication of effort.

- **Generic Teams**

4.9.7 Agreeing the design of the generic team which is built upon the current practice integrated care teams.

4.9.8 Establish the changes needed to enable a patient and carer to have a key worker as the main support through the 2 year programme as needed

4.9.9 Need to agree phased implementation of the generic model possibly through one locality at a time.

- **Specialist Team**

4.9.10 Service redesign of the multi agency specialist palliative care teams looking to palliative care being a 7 day service that would include a hospice at home service.

4.9.11 Hospice at home redesign and business case drawn up for consideration – it is thought that the model would at the least be cost neutral if there is a shift of resource from the acute sector into the model.

4.9.12 Exploring the possibility of a single base for the specialist team.

4.9.13 Identifying the current bed base across Central including own homes, care homes and the need for extra capacity if the balance is moved from an acute bed to a bed in the community – including step up and step down facilities.

4.9.14 Identification of those GPs in Central Manchester with an interest in palliative care and the establishment of an education programme between the consultant in palliative care and the GPs.

4.9.15 It must be noted that there is only 0.6 of a Consultant in palliative care for Central Manchester and therefore if the model is to work, it is a resource issue which will need to be addressed.

Section 5 - Programme Leadership

5.1.1 This new delivery model design is a very ambitious programme of work to bring together numerous organisations and co produce a new delivery model over the next 7 years that will start to be implemented from April 14. Therefore, there will need to be a governance structure that has within it a programme board and subsequent teams with skills that can deliver the change, not only in the service redesign but the supporting infrastructure.

5.2 Estates

5.2.1 We will need to look at the beds available within Central Manchester as currently there are no hospice beds in the city – this will mean assessing the need for support to people in the own homes, care homes and whether we will need to other beds in the community.

5.2.2 The Central Manchester area has three major parallel road systems to consider, Princess Parkway, Oxford Road and Stockport Road. This is important in terms of access for both staff and patients. Congestion is an issue and travelling time can affect efficiency and cost.

5.2.3 The growth of the population in the city centre has increased over recent years with a generally young population without many health resources. The city centre is historically part of North CCG but many of the urgent admission and ambulance activity that arrives at CMFT originates in the city centre.

5.2.4 The new GP provider organisation in Central Manchester is divided into four localities although it is unclear what their estates strategy is.

5.2.5 Whilst co location of different services does not in itself lead to integration it is a major factor in facilitating new ways of working. Integration should be based on the care model addressing the patient need and should not be just across professional boundaries but across organisations.

5.2.6 A hub and spoke model across organisations, as we progress new delivery model designs, would be a consideration for the estates domain.

5..2.7 We will also need to establish whether it is feasible to bring people together in terms being co-located across the city – space, facilities, parking.

5.3 Workforce

5.3.1 If we are to undertake this new delivery model design there is a considerable workforce component across all agencies and carers in terms of:

- bringing teams together – virtually and to co locate
- redesign of teams – roles and skill
- joint training to change culture and raise standards and awareness

5.4 Information

5.4.1 The issue of information both in terms of being able to access information and using information technology to delivery care will be a crucial if the new delivery model is implemented. We would need to

- Access to records across the interface
- Mobile working to enable the delivery of care in people homes
- The production of technology to enable carers ad patients to remain in their own homes and in some cases deliver their own care

5.5 Finance and contracts

5.5.1 The cost benefit analysis has been addressed earlier in the document. However there is a considerable amount of work to be undertaken to ensure that the providers working together in a pre alliance contract, can trust each other to behave in a manner that will achieve the outcomes needed or the new delivery model.

Section 6 - Evaluation and metrics

6.1.1 The Living Longer Living Better programme of work has high level goals which are

- Add years and quality to life (choice of measures in next column)
- Help people to live more independently
- Improve health and social care outcomes in early years (0-4 years) in order to improve school readiness
- Reduce cost & volume of care in hospital
- Increase spend and volume of out of hospital services
- Improve experience of patients/carers at end of life
- Improve patient/carer experience of secondary care (inpatient and A&E)
- Improve patient/carer experience of primary care (general practice, dental services, out of hours)
- Improve patient/carer experience of community health services
- Improve patient/carer experience of social care / support services
- Improve satisfaction of workforce with new delivery models

6.1.2 By designing a new delivery model we believe that we will contribute to these goals. Specifically we believe the new delivery model will enable people to die in their place of choice.

6.1.3 We understand that we will need to be held to account and measured on what the new delivery model aims to achieve. When developing our measures we will want to be clear on:

- Why the indicator is important in the context of the new delivery model e.g. clinically or financially
- How we would expect the NDM to have an impact on this measure
- What impact would you expect the NDM to have on this measure and on the corresponding balancing measures.

6.1.4 We believe some of the metrics we could put in place across our system are :

Reduction in (specifically the EoL cohort)

- AE attendance
- Admission to ward
- out patients
- Lengths of stay
- Readmissions
- admissions to residential homes
- admissions to nursing homes
- NWAS transfers

- These will be balanced by an increase in
- People who die outside of hospital in their place of choice
- Re-ablement services
- identification of people in the cohort by general practice
- activity in services in community settings
- people in the identified group who have a key workers
- people in the identified group who have a care plan
- carers in the indentified group who are known and involved in the care plan

6.1.5 We would want to develop with patients, carers and practitioners experience metrics that they consider important. We would also want to build on work that has been undertaken in previous integrated projects. Areas that we think would be important are:

- Pain and symptoms are managed by a multidisciplinary team.
- Health and wellbeing is optimised during the last year of life.
- There is a well trained and confident workforce in Central Manchester
- Effective partnership working to deliver excellent care that meets the patient/carer needs.
- Patients and families will matter and feel that they matter.

- Emotional and practical support is available.
- Care is co-ordinated across organisational boundaries.
- Patients will be supported in their preferred choice of place of death
- The service will be available to all on the basis of need not diagnosis.

Section 7 – Conclusion and Recommendation

7.1 Conclusion

7.1.1 The document is an initial high level design for a new delivery model for end of life care in Central Manchester. It has considered the emerging commissioner care model and started the design process around 5 specific new delivery model components across a range of providers.

7.1.2 If the initial design was accepted there are still significant issues that will need to be worked through including the financial and contractual envelopes and the detail of how the model would be implemented and over what time scale.

7.1.3 Our understanding is that there is a considerable amount of work to be undertaken between now and the end of March with specific decision making points being:

- 20th December – Central Provider Partnership Board discussion as to whether to agree the initial design. If approved:
- 20th December design to be sent to the City Wide Living Longer Living Better team for inclusion in a January HWB Executive paper
- 8th January HWB Executive meets to discuss the programme
- 22nd January CICB meets to discuss and is asked to approve the initial new delivery model designs
- February and March HWB Executive, CPPB, CICB and HWB meetings to progress the programme of work.

7.2 Recommendation

7.2.1 The Board is asked to:

1. Accept the paper and it being sent to the city wide team
2. Acknowledge the time line and the progression of the paper
3. Acknowledge the work that needs to be undertaken if the new delivery models are to progress and actions needed between now and the end of March

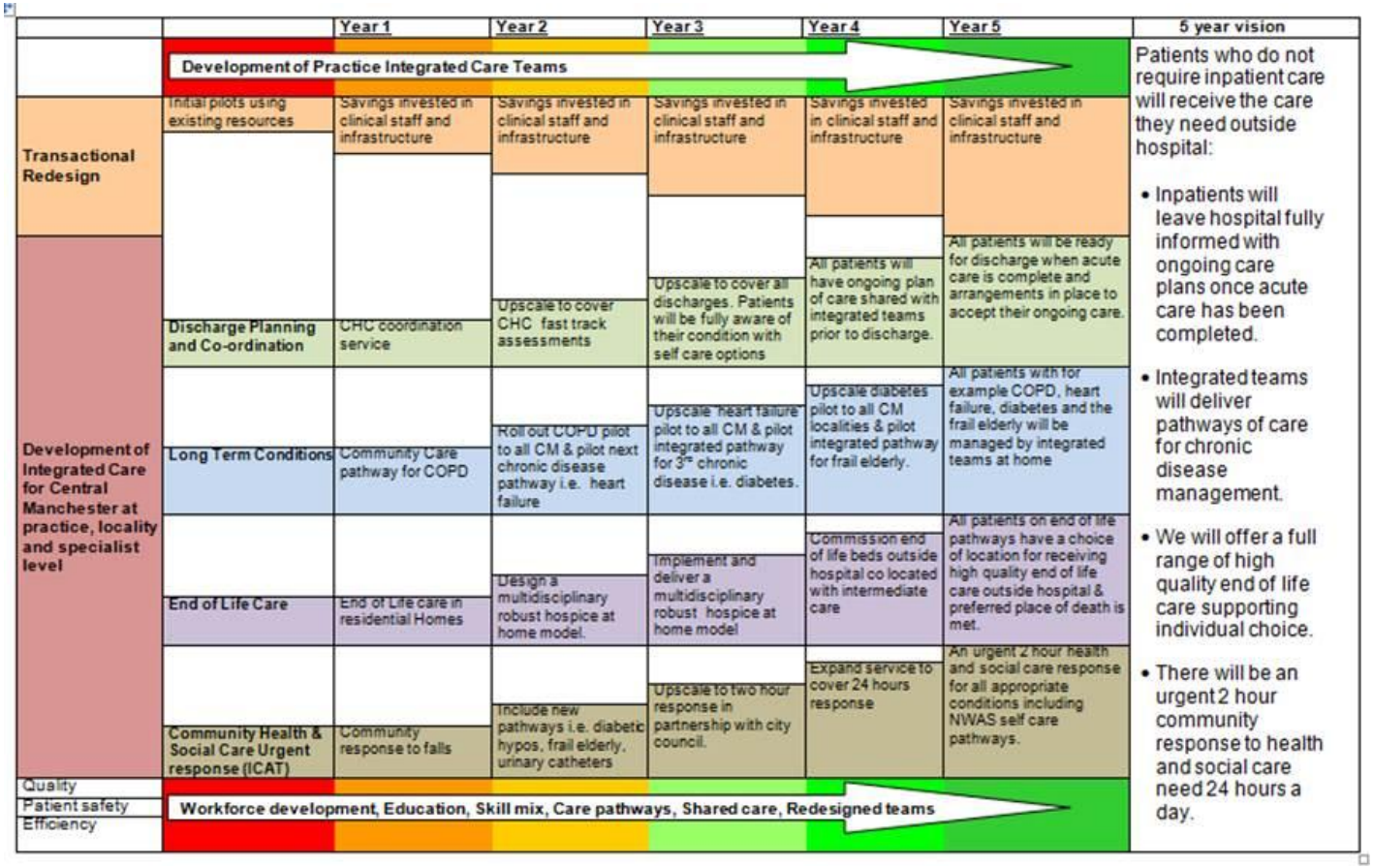
Living Longer Living Better – New Delivery Model Design
Central Manchester

Appendix 1: Participants

		Workshop 1 18.10.2013	Meeting 1 8.11.2013	Meeting 2 20.11.2013	Meeting 3 2.12.2013	Workshop 2 6.12.2013
Andrew Henderson	Marie Curie	☑	☑	☑		
Ashique Ahamed	CMFT		☑	☑	☑	☑
Arwel Williams	CMFT	☑			☑	☑
Basma Al-Kamil	MHSCT				☑	☑
Carmel Breen	Manchester City Council			☑		
Charles Thompson	Marie Curie				☑	☑
Chris Lamb	CMFT	☑				☑
Connie Chen	Dr Chen, Davies and Chavdarov			☑		☑
Dave Williams	Manchester Carers Forum	☑				
David Evans	CMFT	☑				
Debbie Walker	Manchester City Council	☑	☑			
Gioia Morrison	Manchester City Council			☑	☑	☑
Gillian Moncaster	Manchester City Council	☑	☑	☑	☑	☑
Hazel Branney	CMFT	☑	☑	☑	☑	☑
Isabelle Melliss	CMFT	☑	☑	☑	☑	☑
Jane Barcoe	Age Concern	☑	☑	☑		
Janet Carson	CMFT	☑	☑	☑		
Jenna Whisker	CMFT	☑				☑
John McGrath	MHSCT				☑	☑
Julie Harrison	CMFT	☑				☑
Kate Tattersall	CMFT	☑				
Katrina Devall	CMFT	☑	☑	☑	☑	☑
Kathy Hern	CMFT	☑				
Katie Elder	CMFT	☑				☑
Lamb Christine	CMFT	☑				
Lisa Woodworth	Go to Doc	☑				
Lorraine Smith	CMFT	☑				☑
Louise Williams	CMFT	☑				☑
Maria Kane	NWAS	☑				☑
Melliss Isabelle	CMFT	☑				
Morgan Trish	CMFT	☑				
Neil Hepworth	CMFT	☑	☑	☑	☑	☑
Neil Walbran	Health Watch	☑				☑
Patricia Gratton	CMFT	☑				☑
Peter Gomm	CMFT	☑				☑
Prasanna Rao-Balakrishna	CMFT	☑	☑	☑	☑	☑
Rachel McMillan	St Ann's	☑	☑	☑		
Sara Radcliffe	CMFT	☑	☑	☑	☑	☑
Sue Ware	CMFT	☑	☑	☑	☑	☑
Susan Saxon	CMFT	☑				☑
Tim Greenaway	Alexandra Practice		☑	☑	☑	☑
Tina Davies	CMFT	☑				☑
Victoria Entwistle	CMFT	☑	☑	☑	☑	☑

Living Longer Living Better – New Delivery Model Design
Central Manchester

Appendix 2: Adult and Community Services 5 Year Plan



Appendix 3: Supporting Information

The following supporting information is available at request from Katrina Devall. If you would like a copy of any of the documents below, please email katrina.devall@cmft.nhs.uk.

1. **Health and Wellbeing Board reports:**

Living Longer Living Better Blue Print, March 2013
Living Longer Living Better Strategic Outline Case (Part A and B), July 2013
Living Longer Living Better Business Case, November 2013

2. **Commissioner Care Models:**

Adults with Long Term Conditions
End of Life for Adults and Children
Frail Older Adults and Adults with Dementia

3. **Central Manchester New Delivery Models:**

New Delivery Model for Long Term Conditions
New Delivery Model for Frail Older People and Adults with Dementia

4. **Bibliography for the End of Life Care Model Conditions Model**

References

End of Life Care Programme (DH, 2004)
Improving Supportive and Palliative Care for Adults with Cancer (NICE 2004)
End of Life Care Strategy -Promoting high quality care of all adults at the end of life. (DH, 2008).
Ruth K, Pring A,Verne J. Variations in place of death in England. (National End of Life Care Intelligence Network, 2010.)
Office for National Statistics. 2008-based National Population Projections. (ONS, 2009)
Gomes B, Higginson IJ. Where people die (1974-2030): past trends, future projection sand implications for care. Palliative Medicine 2008; 22(1):33-41
End of Life Care Strategy Quality Markers (DH, 2009)
National Forum for Hospice at Home Strategic Framework (2007)

http://www.goldstandardsframework.org.uk

National end of life Care Profiles for Primary Care Trust Manchester

An Integrated New Delivery Model Design for Frail Older People and Adults with Dementia in Central Manchester

Living Longer Living Better – New Delivery Model Design Central Manchester

Author:

David Evans, Head of Quality and Performance, Central Manchester Foundation Trust.

Version 4 agreed by Central Manchester Provider Partnership Board on 20th December 2013.

Name	Organisation
Gill Heaton	CMFT
Dave Williams	Manchester Carers Forum
David Beckett	Go to Doc
Diane Eaton	Manchester City Council
Ed Dyson	Central Manchester CCG
Ivan Benett	Central Manchester CCG
Jon Simpson	CMFT
Mark Edwards	CMFT
Mike Wild	MACC
Neil Walbran	Health Watch Manchester
Sara Radcliffe	CMFT
David Ratcliffe	NWAS
Stuart Hatton	Manchester Mental Health and Social Care Trust
Vish Mehra	Central Manchester GPPO

An Integrated dementia New Delivery Model Design for Frail Older People and Adults with Dementia in Central Manchester

Executive Summary:

This document has been written as a result of people from 10 organisations working together over a two month period, to create a high level design for the new delivery model for people with Frail Older People and Adults with Dementia in Central Manchester. (Appendix 1)

It is a response to Manchester's Living Longer Living Better Integrated Care Programme and has been shaped by the emerging commissioner care model and profiles.

We have taken at the heart of the design the premise that Mrs Pankhurst, her carer, her family and the community she lives in are the main focal point. That any design we deliver should be achieved through partnership and have a change in focus to how we deliver care in the community.
We have broken our design into four components which we believe make up a new delivery model.

- **Coproduction** with patients, carers and the community. A model designed with the people and communities that will use it enabling commissioned and co-ordinated volunteer structure and community hub. When we refer to carers in the document we are referring to unpaid carers.

- **Coordination** a central service point providing an overview and point of contact for all services in the design to enable the model to be delivered across multiple providers.

- **Generic integrated one team** in each locality that can care for a person when they are frail or have dementia.

- **Specialist Team** which provides proactive elderly care.

Our new delivery model is built upon the work that Central Manchester has been undertaking over the last three years under the framework of the Central Integrated Care Board and other partnership initiatives that have developed. However, we feel that if we are to achieve the outcomes of the care model we need to increase the scale and pace of change whilst eliminating duplication.

For the coming year we have listed actions from April including the development of the coproduction approach, co-ordination centre, generic and specialist teams.

We also recognise that any new delivery model will need to have a secure governance framework and infrastructure surrounding it This would include areas such as finance and contracting, estates, information and workforce development. All of which will need to be programme managed through a complex and challenging environment.

Contents Page

Section 1 - Context

1.1 Introduction

1.1.1 The paper describes the new delivery model design for frail older people and adults with dementia, who are registered with a GP in Central Manchester, and their carers. It has been produced by a number of providers working together in Central Manchester and is a response to the Manchester Commissioners Living Longer Living Better (LLLB) care model for frail older people and adults with dementia.

1.1.2 We understand that this is not a final product but is the start of a process by which we, the Central Manchester system, can work together to achieve a vision of care for 2020. A vision which is a coordinated response to a patient and carer's need and is delivered as close to their home as possible.

1.1.3 It is recognised that this is an ambitious programme of work and understand that there is still a great amount of work to be done in terms of quantifying what this means - resources and activity. We also acknowledge the complexity for the commissioners, the need to be able to work with providers differently in order to commission this model of care, over the next 7 years, to achieve the 2020 vision.

1.1.4 We also understand that there is a large amount of work to be undertaken in areas such as workforce, estates and information. This is needed if the model is to be underpinned and delivered in the community in an effective and sustainable manner.

1.1.5 However, we do believe that what we have outlined is the start of a new delivery model design that can achieve lasting change.

1.2 Design Process and Need for Change

1.2.1 Over the last seven weeks there have been two sessions, a range of one-to-one discussions, and written feedback exchanged with individuals from a range of organisations who provide services to Central Manchester patients, who are at the frail elderly or adults with dementia.

1.1.2 This document has been developed from these meetings and workshops. It is our first iteration for what we hope will be an ongoing process of improvement and design to create a new delivery model which will achieve the care model for Central Manchester's population. We also believe that this new delivery models should be seen as a part of a wider system change that includes people with long term conditions and patients in the last year of their life, and using end of life services.

1.2.3 Most people do not define themselves by a medical label and many have more than one condition, therefore we need to see all the new delivery models as being around the person and therefore sharing many design elements.

1.2.4 A customer and patient engagement event was held in December to engage patients their families and carers around the key themes in the care model.

1.2.5 Over 63 people attended and out of them 45 would like to continue to be engaged in how we go forward. The event was based around asking questions on the present and future care model and some specific issues are contained in the later section on co production.

Section 2 – Commissioning Profile

2.1 This design is a response to the Living Longer Living Better Frail Elderly and Adult with Dementia Care Model produced by Manchester Commissioners. The care model describes the offer, outcomes, measures and standards for this population group.

Living Longer Living Better – Frail older Adults and adults with dementia

Prevention and Self Care

Everyone is able to maximise the opportunities to improve their health and wellbeing

Commissioner Expected Outcomes

- There will be less people admitted to hospital after a fall
- More people will take exercise
- More people will eat healthier
- More people will have a medication review annually
- More frail older adults will have immunisations e.g. flu, phenomena
- Buildings will be planned using long term adaptability
- Kerbs, roadways will be hazard free
- One tool is used to identify frailty
- An online directly of care an support will be available

Measures for Success

- Less unplanned admissions to A/E
- 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

What will be different for residents of Manchester?

- I can access an online directory of advice, information, care and support including exercise groups
- I will have an annual medication review
- I will be able to easily access support to stop smoking, lose weight, reduce alcohol intake
- I will not fall on broken pavements or uneven roads
- My home will be safe for me to move around
- I will have my annual immunisations
- I will be able to ask for help if I am losing skills or strength
- I will use the how to guide to prevent falls and illness

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 over 65years
- Any admitted to hospital in an unplanned way will be logged and followed up

Living Longer Living Better – New Delivery Model Design
Central Manchester

Living Longer Living Better –Frail older adults and Adults with Dementia
Coordinated Care Planning
Every one has an agreed individualised care plan.

Commissioner Expected Outcomes

- All frail, elderly Adults will have a multi agency care plan that is reviewed after any lapse in their health or care/ admission, it will be accessible to all professionals, (including residential and nursing homes) – renewable by phone or Skype
- Care plans will follow the person in/ out of hospital intermediate care or community

Measures for Success

- Reduced admissions as NWAS use agreed alternative community options for support plans
- Reduced length of stay
- Less disruption to frail older adults
- improved satisfaction of care and support

What will be different for residents of Manchester?

I will have one plan for my care – coordinated by a Lead professional

My plan will cover any changes in my needs both at home and in a crisis

The plan will focus on my goals and I will have a copy. It will be shared with anyone who needs it to provide my care

The plan will focus on keeping me at home

The plan will include my carers, friends and any equipment, technology needed

I will be able to access support (care 24/7) and will be consistent

System Standards

- One shared care plan across whole Health and Social Care system
- Frail elderly stay are diverted and A/E to an elderly care point
- Consistent care is delivered
- Community responds within 4hrs as agreed in care plan
- Lead worker identified for frail older adults and adults with dementia
- The system responds 24/7
- Hospital staff work outside hospitals
- GPs work across patches to utilise skills
- Social Care provide consistent carers (home care)
- Reablement/ Intermediate Care integrates

Living Longer Living Better – Frail older Adults and Adults with Dementia
Access
Everyone will have timely access to information and services

Commissioner Expected Outcomes

- A shared online directory of information, advice, care and support is available and up to date
- Voluntary sector organisations and community self help retain support included

What will be different for residents of Manchester?

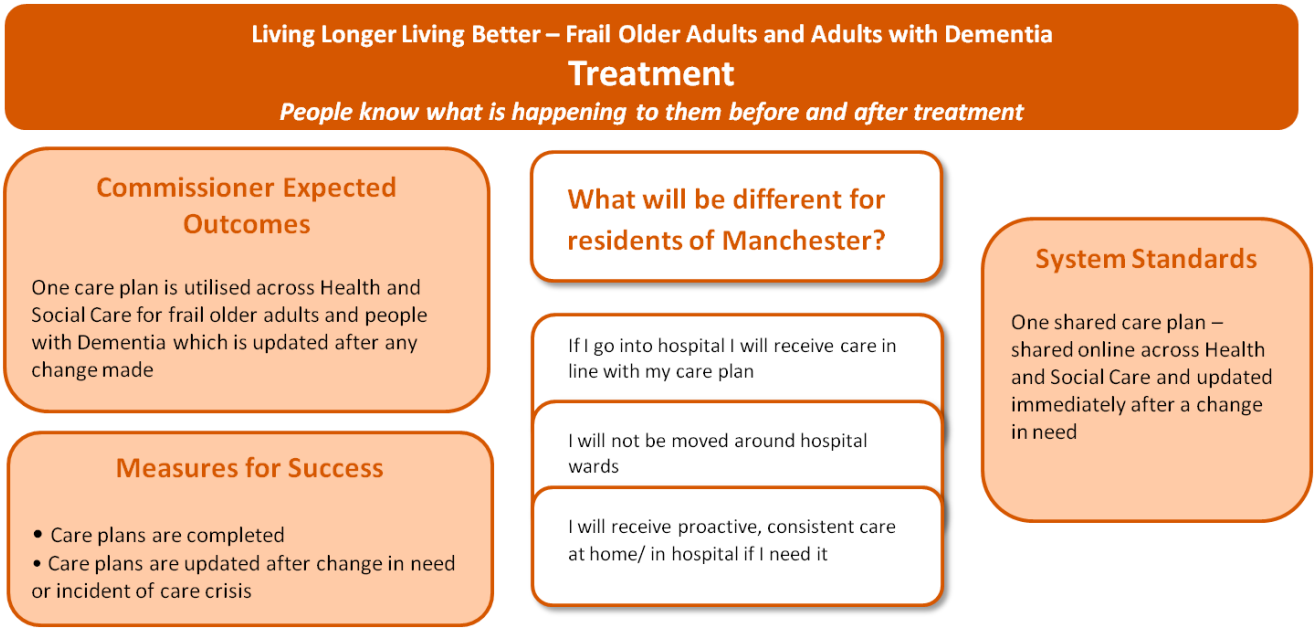
One central online tool is available to access information I need

Measures for Success

- Online directory is available
- One directory is used by all sectors

System Standards

One shared tool for information, advice, care and support agreed and used to develop individual care plans by public carers and professionals



2.1.1 Manchester has a lower proportion of its population aged 65 plus than other core cities, and the 2011 Census shows a drop in all older age groups except those aged 90 plus. However the latest projections produced by POPPI (Projecting Older People Population Information) predict a steady growth in overall numbers over the next 20 years, with the total population 65 plus increasing from 50,000 in 2012 to 63,000 by 2030.

2.1.2 Manchester's older population continues to feature high levels of deprivation. In the main older people in Manchester are financially poorer, in poorer health, and more likely to live in social isolation than their counterparts in the rest of the country. They are therefore more likely to suffer from dementia, other illnesses and long term conditions and are likely to need care and support to help them (and their carers) to manage as independently as possible.

2.1.3 The Income Deprivation Affecting Older People Index (IDAOPI) measures adults aged 60 or over living in pension credit (guarantee) households as a percentage of all adults aged 60 or over. The IDAOPI shows that the worst Lower Super Output Area (LSOA) in Manchester, around Cheetham Hill Road in Cheetham ward, is ranked 139 in England. There are nine LSOAs in the most deprived 1% in England, one less than in 2007. 145 of Manchester's LSOAs (almost 56%) saw improvements in their rank position between 2007 and 2010. However, conversely the relative positions of LSOAs in Woodhouse Park, Moston, Didsbury East and Didsbury West deteriorated most in the IDAOPI by over 3,000 places.

2.1.4 Some Epidemiology of fall in Manchester

It is widely recognised that obtaining accurate data on falls is problematic. It is also likely that many falls are not reported. When people do report, the fact that a fall is a "symptom" and not a "diagnosis" means that there is no precise coding of falls.

2.1.5 Information from the National Injury Profiles allows us to build up broad picture of falls related injuries and mortality in Manchester. In summary, the data shows that compared with England as a whole, Manchester has a significantly worse rate of:

- Mortality from unintentional (accidental) falls
- Hospital admissions due to injuries arising from unintentional (accidental) falls
- Hospital admissions (and emergency hospital admissions) due to an unintentional fall in older people aged 65 and over

2.1.6 In 2010/11, there were 2,313 hospital admissions resulting from an accidental fall among older people aged 65 and over in Manchester. This is equivalent to a rate of 3,457. per 100,000 population compared with the England average of 2,475

2.1.7 Over 60% of older people admitted to hospital as a result of an accidental fall are admitted as an emergency. In 2010/11, the emergency admission rate among this age group in Manchester was 2,183 per 100,000 population compared with the England average of 1,978.

2.1.8 Public Health Manchester and partners therefore identified "falls in older people" as being a serious Public Health issue for the city and was highlighted as an priority in the 2011-12 Manchester Joint Strategic Needs Assessment (JSNA)

2.3 JSNA- Dementia National and local context

2.3.1 The report Dementia UK, published in February 2007, provides the most up-to-date evaluation of the numbers of people with dementia in the UK, projections on numbers of people in the future and the prevalence of dementia. The figures from Dementia UK have been updated to bring them into line with current population data. These figures are summarised in this section and were published with the launch of the Alzheimer's Society Dementia 2012 report.

2.3.2 There are around 800,000 people in the UK with a form of dementia. It is estimated that by 2021 there will be one million people with dementia in the UK. This is expected to rise to over 1.7 million people with dementia by 2051.

2.3.3 Dementia in people under the age of 65 is comparatively rare. There are over 17,000 younger people with dementia in the UK. However, this number is

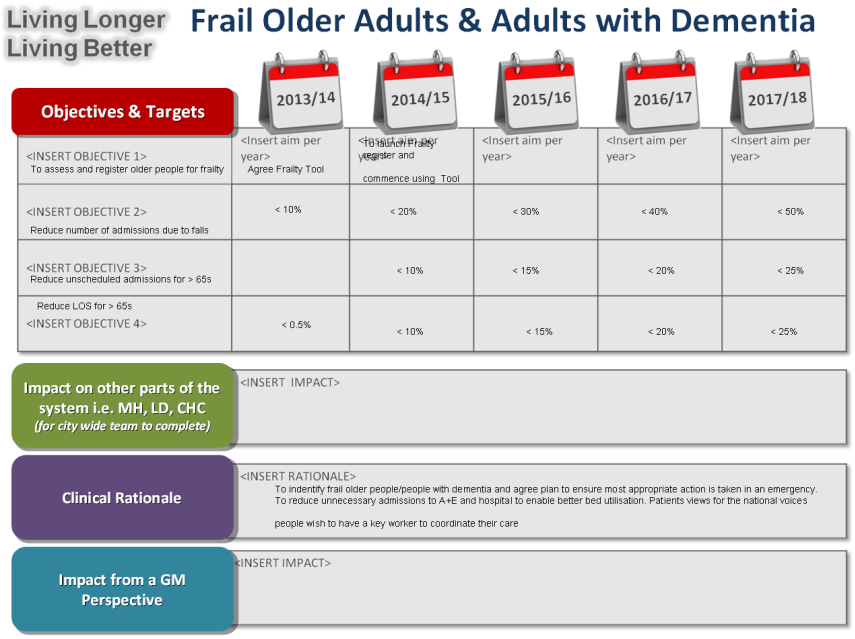
likely to be an under estimate and the true figure may be up to three times higher. Data on the numbers of young onset cases are based on referrals to services, which can significantly underestimate the numbers, because not all those with young onset dementia seek help early in the disease course. Alzheimer's disease is the most common form of dementia. The proportions of those with different forms of dementia can be broken down as follows:

- Alzheimer's disease (AD): 62%
- Vascular dementia (VaD): 17%
- Mixed dementia (AD and VaD): 10%
- Dementia with Lewy bodies: 4%
- Fronto-temporal dementia: 2%
- Parkinson's dementia: 2%
- Other dementias: 3%

2.3.4 Excessive drinking is a risk factor for developing dementia. Someone regularly drinking more than the recommended levels of alcohol significantly increases their risk of developing dementias such as vascular dementia and Alzheimer's disease. Korsakoff's syndrome is a brain disorder usually associated with heavy alcohol consumption over a long period. Although Korsakoff's syndrome is not strictly speaking a dementia, people with the condition experience loss of short-term memory and there is possible relationship with Korsakoff's syndrome and 'alcohol related dementia'. Alcohol consumption is increasing in the UK and therefore these conditions are expected to become more common in the future.

2.4 Commissioned Shift

2.4.1 The following are a series of first draft diagrams produced by the commissioners to look at shift. Further refinement of the tables will continue but this is a good starting point by which the new delivery model can start to be designed. These were received too late for review prior to design and therefore we will need to work with our commissioners to understand the targets and objectives in more detail.



2.5 Finance Profiling

2.5.1 To support the financial assessment of the new delivery models being developed under the LLLB programme, a finance and contracting work-stream has been established with representation from all eight partner organisations across Manchester. From December 2013 to March 2014, the workstream will focus upon:

2.5.2 **Financial context and goal setting**: agreeing commissioners' affordability and cost envelope - based on the agreed scope of services, current spending baselines, assumptions about investments, stretching efficiency goals, phasing of implementation and a shared understanding of transitional support costs.

2.5.3 **Stakeholder engagement and governance**: shared financial planning methodologies and assumptions across the eight partners, linked closely with the LLLB programme to ensure appropriate governance.

2.5.4 **Financial modelling and business case development (Cost Benefit Analysis):** testing the desired impact of care models in the context of the LLLB financial model to understand the cost implications of changes in demand and service provision. This is a crucial step in terms of developing the business cases that will be required to secure investment in 2014/15 and beyond as integration plans expand across wider population groups. <u>The costs of new delivery models must be affordable within the financial context.</u>

2.5.5 **Contract development:** exploring the scope, risks, benefits and pace of implementation for alternative models of contracting to reflect the new delivery models.

2.5.6 **Better Care Fund:** describing and agreeing the financial implications of the LLLB programme and its impact upon partners, in particular, the acute sector, within the Better Care Fund plan (including agreeing performance baselines against the four national measures that are linked to payment).

2.6 Pre Alliance Contract

2.6.1 Partners in Central Manchester's health and social care system are working to develop an Alliance contract around urgent care services. The aim of this is to align goals between providers and commissioners, to collectively reward achievement of goals and to support a movement of resource to increase out of hospital care. The full alliance will commence in 2015 but a pre-alliance contract is planned for 2014 which will incorporate these same aims.

The relevance to the implementation of new delivery models is in two parts.

1. The pre-alliance will have a performance related pay framework which includes both implementation of New Delivery Model and achievement of outcome measures.

2. The pre-alliance plans to have the means by which money can move within the overall contract to support investment planning.

2.6.2 These are designed to support and enable the development and resourcing of New Delivery Models for LLLB. Organisations are now working together to put in places this contract arrangement for April 2014.

2.7 Provider Response to the Commissioning Profiles

2.7.1 As a group of providers we have considered the commissioning profiles as they currently exist. We believe we can work together to produce a joined up, co-ordinated design which we believe will achieve the outcomes, benefits and standards as identified above. However there are issues that need to be considered:

2.7.2 We will need to explore in more detail the objectives and targets to ensure that they are understood by providers and we can be confident not only of delivering them but them being understood and measured.

2.7.3 We are aware that changing services cannot be achieved overnight and there needs to be a period of development, evaluation and shift to enable sustainability. Therefore the timeline in which the new delivery model is

implemented is crucial and will need to be phased in and delivered over a number of years to achieve the full model.

2.7.4 There is the issue of understanding the current resource envelope for this care model across providers, and any future resource envelope that we need to work within. Without this information the new delivery model we have put forward is un-costed and therefore will need to be reassessed in the light of the financial envelope and the transitional resources available when known.

2.7.5 Many of the providers in the new delivery design, but not all, are part of the pre alliance contract work. This poses an issue as to how we will ensure that all providers that are within a new delivery model are working to the same contractual framework as those in the pre alliance contract.

2.7.8 There is also the issue that the new delivery models will by their nature cross many providers and therefore there is the issue of the providers understanding and agreeing the joint targets and objectives that they will need to achieve together.

2.7.9 We also feel that there are significant implications for the new delivery models in relation to the Care and Support Bill. The Care and Support Bill aims to prevent and reduce needs, put people in control of their own care and clarify entitlements to care and support. The bill will come into effect from April 2014 and will be fully implemented in Manchester by April 2015.

2.7.10 From April 2013, the local authority will be responsible for using national minimum eligibility criteria to identify any people who have an unmet care need, completing initial assessments to establish whether people are eligible for care, completing financial assessments to determine who will pay for the care and providing personalised care and support plans to people and carers where required. The bill also gives legal entitlement for an individual to receive a personal budget which outlines the total cost of providing their agreed care plan. These duties will apply to all people irrespective of whether they are funded by the local authority or self-funded. The bill gives the same rights to carers as those given to the people they care for.

2.7.11 Manchester Local Authority already calculates and informs people of their individual budget allowance based on eligibility and needs assessment.
There are significant financial implications from the bill which will need to be taken into consideration. The financial impact cannot currently be reliably modelled and there is a very high level of uncertainty and risk around the financial implications of the bill and its impact on a new delivery model.

Section 3 – Current Provision

3.1.1 In this section we have worked as a collection of organisations to piece together what we view is the current provision profile. This section is at a

very high level as we only know what we know in the room at the time, and therefore there may be other services that are commissioned, or pilots being undertaken, that we are not aware of, and therefore not outlined.

3.1.2 The Central Manchester system has a strong foundation of integrated working across a range of providers. This is both under the framework of the Central Integrated Care Board and outside it with different partners. There has been particular success in the last two years in implementing practice integrated care teams in 25 practices and a range of intermediate care services. These have formed what is labelled the "five year plan" (appendix 2) and much of the design in this document is predicated on these developments underpinning future design.

3.1.3 We are also at a very early stage of working together in a co-production methodology as a provider group. It is comfortable to look at change for the future and acceptable to look at current issues - it is more difficult when we need to share activity, data or financial information which may be sensitive. We have numerous business cases across the organisations for various parts of a potential new delivery model. These are known, but we have not shared them, until we are clear on the process from April to implement parts of the NDM.

3.4 Current Provision by location

3.4.1 Whilst it was acknowledged that there are existing services providing excellent care to frail elderly and patients with dementia, this is not formally coordinated and often relies on informal networks and communication systems. The table below gives an overview of health care provision; This is not an exhaustive list, but provide a sense of the wide range and complexity of services and highlights the potential for 'silo' working between providers; thus increasing the risk of duplication, patients telling their story many times and for breakdown in communication.

Provider	Community co-operative	Provider	Community integrated care	Provider	Specialist proactive elderly care
ACM	Daycentres	GPPO	GP extended hours	CMFT	Care of the Elderly outpatient clinics
ACM	Home Domestic / Social support	CMFT	District nursing services	CMFT	Care of the elderly acute care
MCC	Grand Day out scheme	CMFT	Active case management	CMFT	Accident and Emergency Services
MCC	Neighbourhood networks	CMFT	Community Nursing Home Support	CMFT	Acute Medical Assessment
MCC	24 hour care	CMFT	Falls service	MMHT	Psychiatric Liaison for patients >65
CF	Carers Forum - Mentor network	CMFT	Homecare pathway (rehabilitation)	CMFT	Discharge planning
CF	Carers Forum - Mentoring	GPPO	Care home enhanced	GPPO	GP in reach to acute

	for dementia carers		service		services
MCC	Joint equipment stores	CMFT	IV Sub-cut therapy in the community	CMFT	Complex Healthcare Co-ordination
Other	Private social care agency providers	CMFT	Rapid response team	CMFT	Complex discharge service
Other	Residential homes located in central Manchester	GP	Primary integrated care teams	CMFT	Home from hospital service
Other	Nursing Homes	CMFT	Active case managers	CMFT	Chaplaincy
MCC	Safeguarding Adults Team	CMFT	Intermediate Care Assessment Team	CMFT/MCC	CHC
MCC	Carers Support	MCC	Reablement (step up/step down)	MMHSCT	Later Life Community Mental Health Teams
MCC	Equipment & Adaptations Service	CMFT	Intermediate care beds (step up/down)	MMHSCT	Bridges Day Unit
MCC	Healthy Lifestyles	GPPO	Take home and tuck in service	MMHSCT	Early on set dementia Team
MCC	Home based support	GPPO	Dementia enhanced service		
MCC	Nursing Homes Respite	CMFT	End of life support		
MCC	Community Care Assessment	GP	GPs and Central Manchester GP Provider Organisation		
MCC	Carers Needs Assessments	GP	Out of hours medical services 'Go to Doc'		
MCC	Equipment and Adaptations, Assistive Technology and Community Alarms Assessment	MCC	Social Work and Primary Assessment Service		
Public Health	Age-friendly Old Moat project	MCC	Specialist & Regional Social Work		
Public Health	Chorlton Good Neighbours	MCC	Contact Centre		
Public Health	Valuing older peoples network	MCC	Emergency Duty SW Team		
Public Health	Healthy lifestyles service	MCC	Blue Badge Team		

3.5 Services impacted by the new delivery model

- Bed management teams
- Clinical 'speciality teams' i.e. Renal, Cardiac, Respiratory, Cancers
- Safeguarding
- Sodexho facilities management systems (portering etc)
- Pharmacy
- NWAS & Arriva

- Informatics - sharing of information, risk management, alerting systems, pathology labs (for rapid requests of turning around a patient in A&E)
- Hospital at night teams
- Clinical nurse specialist across CMFT

3.5.1 Care Concepts- (A service that provides general Homecare, Day Care and Respite, along with a Dementia Outreach Service which provides practical support (sit in or outing services) to meet the assessed needs of carers - locality dependent.

3.6 Central Manchester CCG Demonstrator Site

3.6.1 In 2013, Central Manchester CCG successfully secured a Demonstrator Community Site bid which crosses all GP practices in Central Manchester. The expectation from the Greater Manchester Area Team is that projects will be able to show demonstrable outcomes and benefits by April 2014. It is important that any new delivery model in Central Manchester takes into account the demonstrator site's projects and the possibilities of integration rather than duplication for future sustainability.

3.6.2 A summary of the projects is listed in the table below:

Domain	Project	Rationale/model
Access *Improved access through collaborative working across practices extending availability and responsiveness.*	**Responsive Access**	Practices to adhere to quality standards of responsiveness to patient urgent and same day need.
	Primary care availability	Increase primary care available hours – to 8pm weekdays and 3 hours per day weekends, total 16 pw, through collaborative local arrangements.
	Primary care Homeless access	Specialist primary care through services at individual practices; potentially ensuring CCG wide co-ordination through GPPO.
Long term conditions *Improved Care through ensuring access to enhanced primary care services.*	**Long term conditions – Diabetes/HF**	To ensure population coverage of existing enhanced services for Heart failure and Diabetes.
	Patient education for people with LTC	Inhaler technique project through community pharmacy.
Patient Voice *Improving engagement and involvement of patients in their own care.*	**Dementia**	Population coverage for enhanced care for patients with Dementia
	Care Homes	Enhanced primary care medical and nursing services for patients in residential care and nursing homes.
Specialist primary care *Closing the gap between primary and secondary care through*	**Persistent pain management service**	Pilot service for patients who experience persistent pain lasting longer than 3 months. Commissioned from specialist acute provider, delivered through specialist primary care service.
	GP led in-reach	Provide additional medical input to patients

improving specialist primary care services.		admitted to CMFT, to support timely discharge and coordinated care in the community. Initially pilot practice, possible roll out following evaluation.
	Access to specialist consultant advice	Increase the number of routine Specialist Consultant Advice lines with main local acute provider, CMFT.

3.7 Summary of Issues with the current Provision

3.7.1 The initial mapping of the current services has raised specific issues that will need to be addressed as we develop a new delivery model:

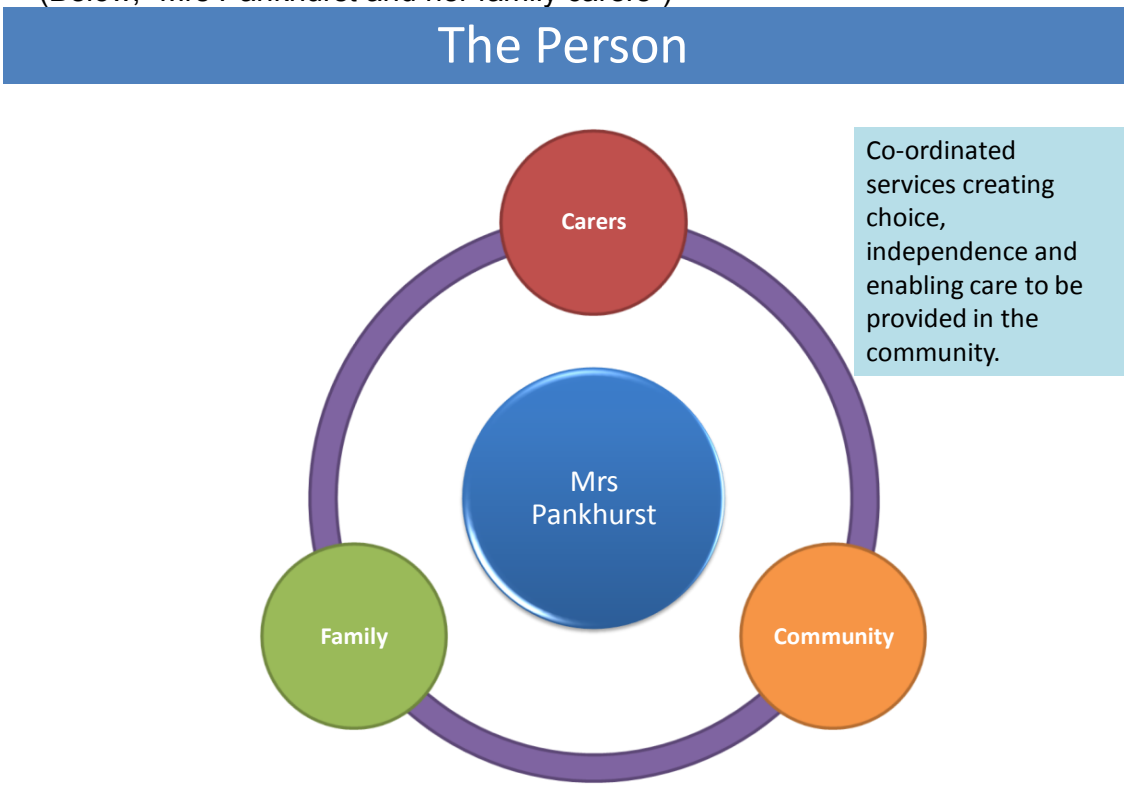
- The services and projects are currently fragmented across service and organisational boundaries - care pathways do not support moving a patient quickly to their place of choice i.e. outreach from the acute sector or rapid care into patients' homes.
- There is no single point of access for patients/carers or practitioners to navigate the many services currently available. Therefore care becomes difficult to understand, what's available and how to access.
- The services are not seven day or 24 hour across the range provided and because of fragmentation there is no understanding of how a 24/7 service could be co-ordinated and provided
- Continuity of care is variable, currently key workers changes between care settings rather than a person having the key worker that knows them most regardless of where care is being delivered.
- Delays in discharge can be caused by a lack of confidence or trust between clinical teams involved
- Frailty assessment and dementia assessments are not undertaken early enough
- There is no community consultant to provide specialist medical assessment outside of the hospital setting. The consultant cover is very limited.
- There is no community developed model to foster a volunteer workforce and use the potential we have in areas such as CMFT volunteer's service.
- There is limited facility for out of hours access to diagnostics, equipment commissioning micro packages of care

Section 4 - The New Delivery Model Design

4.1.1 As providers we totally endorse the need to see the person rather than the patient and to work with, involve and learn from the carer, the family and the community.

4.1.2 We endorse the symbol of Mrs Pankhurst for our new delivery models and the need to look at how the individual is central to all that we do, and their care is defined by their choices and their lives rather than our organisational structures.

(Below, "Mrs Pankhurst and her family carers")



4.2 BY 2020

4.2.1 In exploring what a new delivery model design would mean for the registered adult population of Central Manchester, and the current providers that deliver services, we have assumed that by 2020 we will need to:

- Achieve the commissioned care model
- Deliver co-ordinated services, across providers, which identifies and plans with people who are frail and/ or have dementia.
- Delivers a model predominantly in the community, focuses on ageing well for the individual and their carer.

4.2.2 We believe our NDM design will be delivered with

- dignity and respect;
- in familiar surroundings in the community
- in the company of close family and/or friends
- coordinated for the patient and carer – no gaps no hand offs
- allow for and support the ambition for frail older adults
- enable families and carers to continue to care for their loved one
- enable the greatest level of independence possible

4.3 The Components of our Design

4.3.1 The new delivery design group see there are three key components of the design:

4.4 Community co-operative

4.4.1 We all have something to give, and we all need support of one another the model needs to side step the imbalance between givers and receivers of health and social care. Example: The community milk round / dinner club / housing /urban planning. This ties in with the notion of coproduction, identified as part of the Long Term Conditions, and End of Life LLLB models, whereby coproduction with patients, their carers and the community is key. We believe that the new model will provide care wherever a person is in the community be that in their own home, a residential or a care home or hospital.

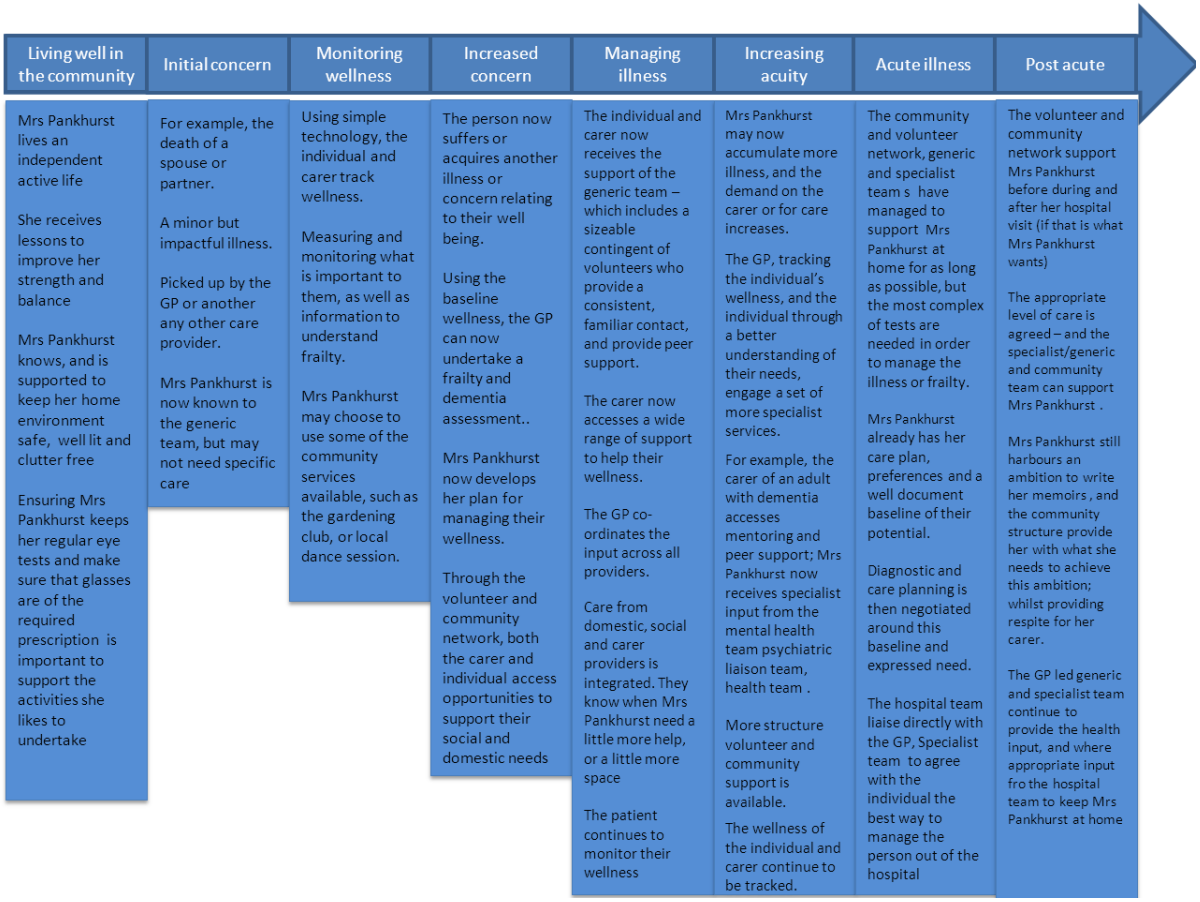
4.5 Community integrated (generic and specialist) teams

4.5.1 Provide a team that identifies and wraps around the needs of the population. Support teams, social care & health teams follow patients from community into hospital. Avoiding admission where it is safe and appropriate. This shares the same focus as the Long Term Conditions, and End of Life models. This is based upon generic teams in each locality that can care for a person throughout their (and their carers) journey to frailty regardless of where they live in Central Manchester, their own home or a care home. The teams are known and consistent and can include individuals from non-statutory organisations. Further supported by specialist team from one hub**,** a joined up multi agency team that will be able to give care to a patient and their carers regardless of where they are living. Importantly all three models also identify the need for improved coordination. A central service point providing an overview and point of contact for all services in the design to enable the model to be delivered across multiple providers and multiple settings. This includes GP/ Practice as a key to community based hubs.

4.6 Specialist proactive elderly care team

4.6.1 Develop the hospital based team to complement the community provision through the expansion and provision of expert specialist advice and care. Focus on avoiding admissions; appropriate diagnosis and supporting early appropriate discharge, as well as, over time, the consultants will out reach into local community hub teams so the expertise is available in communities.

4.6.2 To illustrate this in terms of Mrs Pankhurst's pathway:



4.6.3 The long term conditions pathway and end of life pathways are connected through the generic team, who ensures the individual and carer access the appropriate care.

4.6.4 In the section below we expand the description of the new delivery model.

4.7 Community Co-operative – developing and supporting ambition

4.7.1 We share the same vision as the long term conditions and end of life model with regard to co-production. This design is at a very early stage and we know that what we have in place in 2013 will not be what we will aim for in 2020. However, one of the main areas that we feel we need to address is the ability to work with local communities in a way which enable us to co produce and design models for the future.

4.7.2 We need to create a different culture and design platform where patients, carers and the community are co producing what the 2020 services will be. We want to build an infrastructure of community volunteer support which is the foundation block of our model design in 2020.

4.7.3 We believe co production should cross all new delivery models in Central Manchester and we would want to work with others to see whether it could be a model for the whole of the city. In designing a new way of working together we would look to address the aspects of co production as outlined by the Social Care Institute for Excellence (2013), Co-production in social care, what it is and how to do it, http://www.scie.org.uk/

4.7.4 Co-production is much more than just going out to consultation or co-creation where service users are involved in design. It is about seeing service users as equal partners with shared power and involving them in design, delivery, decision making and evaluation. To do this properly there will need to be radical changes to culture, structure and practice and this change will need to be accompanied by movement of resources to the people using services and frontline staff.

4.7.5 Co-production will need to run through the culture of our health and social care partners and a shared understanding about what coproduction are the principles for putting the approach into action and the expected benefits and outcomes will need to be agreed. Organisations will need to develop a culture of being risk aware rather than risk averse.

4.7.6 Everybody who will be taking part in the co-production process will need to be involved from the very start and people must be valued and rewarded for their contribution to the process. Sufficient resources for covering the cost of co-production activities in Manchester will need to be agreed.

4.7.7 Everything in the coproduction process must be accessible to everyone taking part and nobody should be excluded. Training and support around the principles of coproduction will be required and the people involved need to be given enough information to fully take part in coproduction and decision making. Policies and procedures should promote the commissioning of services that use co-production approaches and frontline staff should be given the opportunity to work using coproduction approaches. The use of an independent facilitator to support the process of coproduction should also be considered.

4.7.8 There will need to be regular reviews of the co-production process to ensure that the agreed principles are being followed and a real difference is being made. The people and carers who use services should be involved in the evaluations and reviews and contribute towards designing how the impact will be measured. Findings should be used to improve the principles of the coproduction process so that continuous learning can take place.

4.7.9 The December event was a very first, small step in the process of working together. When asked at the December customer and patient engagement

event how well do you think health and social care services work for care of the elderly now.

- 3% good
- 13% average
- 32% poor
- 18% very poor
- 12% don't know.

When asked after hearing about the new care model what do you think.

- 40% said it would improve things for patients and carers
- 20% said it would not make a difference for patients and carers
- 5% said it would make things worse for patients and carers
- 23% were not sure

4.7.10 Obviously we have a lot more work to do on how we work with patients and carers to co-produce designs and implement appropriately.

4.7.11 To expand on the meaning of co-production for Frail Elderly and Adults with dementia we suggest that ageing well requires local and meaningful tools to support the person and their carer. The priority is to ensure the ambition of the person, carers and community are understood.

4.7.12 Our vision is of an age-friendly city. The World Health Organisation describe this as one that encourages active ageing by optimising opportunities for health, participation and security in order to enhance quality of life as people age.

4.7.13 In an age-friendly city, neighbourhoods have a particularly important role to play: providing basic services for older people (within easy reach); offering networks of social support; and providing older people with opportunities to take part in and give back to the community in which they live. Neighbourhoods also provide an important sense of community and place (particularly within the context of unsettling urban change). As people start to spend more of their time in neighbourhoods in their later years, there is a growing reliance on those structures that exist at a neighbourhood level, as well as a growing attachment to local neighbourhoods. This is why age-friendly neighbourhoods are a key part of forming age-friendly cities, and supporting older people's everyday quality of life and wellbeing.

4.7.14 The Age-Friendly Manchester programme builds on Valuing Older People's locality approach and its extensive neighbourhood networks to create a series of age-friendly neighbourhoods across the city. This means working to help make the physical and social fabric of these neighbourhoods more age-friendly. For example, supporting design schemes that improve the physical

environment and green spaces of local neighbourhoods; improving access to local services; supporting programmes that reinforce networks of social support and build a sense of local community; and allowing older people to take part in, feel involved in and contribute to the life of the local neighbourhood in which they live."

4.7.15 Providing opportunities for the local community to volunteer and become a part of the caring structure is crucial, for two clear reasons 1) it provides valuable and meaningful resource to those who need support; and 2) it provides a benefit to the volunteer through active engagement in services, and when necessary a proactive path to access services when they, themselves, need it. Finally this network provides the thread across the community that helps to identify when support – in any form – is required.

4.7.16 When it works, it has the ability to personalise what “normal” is, and support individuals to have ambition, be that to complete a jigsaw, build a 24” poly-tunnel or write your memoirs.

4.7.17 Volunteering focuses on support both for the individual and the carer, ensuring both have the appropriate and timely support.

4.7.18 It is important that people are able to feel important and have personal goals for their lives, a sense of “personal ambition". Keeping active and well is not something you achieve with a prescription or a professionals intervention. It is about feeling valued for the part you play in life, your relationships, who you are, and having a purpose and reason to get up, it is about motivation!

4.7.19 Maintaining personal resilience to cope with life and the events or situations you are faced with. This isn't linked to age. Having this purpose enables you to keep mental and physical well-being, and share and influence other people you know. This vision emphasises the need for the community to support the individual to live an independent life support them to be “out and about” safely. We can learn from the Falls Prevention work to identify contributing factors that if managed early can reduce the risk of falls and associated social, medical and psychology difficulties that follow. The community co-operative provides the support mechanisms to be there for the individual, to know about and spot hazards that can contribute to illness, and support the individual to maintain their independence.

4.7.20 As with the Long Term Conditions and End of Life Model our vision would include the development and support of Co-ordination centres (navigators) providing all the individuals involved in providing care can identify the broadest range of potential solutions.

4.7.21 Our vision for the frail elderly and adults with dementia, for the community co-operative element, is best described by six existing services:

1) Age Concern Manchester Crossacres Community Centre with integrated domestic and social care (family stories are available that illustrate the significant impact this model has supporting ageing well)
2) Carers forum network
3) Carers forum mentor programme
4) Grand day out scheme
5) Neighbourhood networks
6) Age-Friendly Manchester programme and the Age-friendly Old Moat project
7) Valuing older people programme

4.8 Community integrated (generic) teams – developing and supporting ambition

4.8.1 Providing support to ageing well requires input from many different teams. The priority is a) to ensure these teams have the information from all the teams involved to provide the most appropriate plan for the person and carer; and b) a consistent relationship is built with the person and family.

4.8.2 When care is truly joined up, we can stop the individual or carer having to repeat their personal information and plans. We can also ensure when we make a frail assessment, and/or a dementia assessment, we share that information appropriate between us and utilise this as the basis for agreeing an early intervention with the individual and their family.

4.8.3 In our vision, because of the community co-operative we already provide a support structure to support and identify individuals that are starting on their journey to frailty we can identify and assessment these individuals and families early on. The use of a community based frailty assessment (including dementia) tool is fundamental to ensuring the appropriate care and plan can be arranged. This tool supports a discussion between the GP and Individual about wellness, and social need, as much as illness.

4.8.4 The community integrated teams would be led by the GP, and engage with the appropriate services (with the support of the co-ordinate centre) the correct teams, and ensure a consistent and joined up message is discussed with the individual and carer. The co-ordinate centre, and therefore the model, can be accessed through a single point of contact – we are assuming this would be a one number gateway.

4.8.5 A single number would provide the caller with a person as the point of access to be able to signpost and navigate the practitioner, patient or carer through the menu of services as required.

4.8.6 We would expect this service to not only be able to give advice but if needed that the service would also be able to micro commission services for the patient, carer or practitioner which are appropriate e.g. rapid access to CHC, access to equipment, access to beds across the community, rapid access to volunteers, medicines or diagnostics.

4.8.7 We realise that this is a highly ambitious idea and we believe it should cross all the new delivery models and in some instances Manchester as a whole if appropriate. We believe that there is no future in organisation's modelling their own gateways which produces numerous single numbers for people with multiple conditions, and if we looked to combine our resources and expertise we could design and provide a highly skilled effective and responsive service

4.8.8 The individual will also be supported by one nominated individual to co-ordinate their care. The person, maybe the individual themself or a carer, or an appropriate individual from a care provider, it should not always default to the provider organisations. At times, the individual or their carer have the right to choose who this is, and their decision may change over time, for example the carer may need a break from co-ordination responsibilities. The co-ordinated team can access a co-ordination centre (navigator) as a tool to help identify the most appropriate range of solutions for the patient.

4.8.9 The community integrated teams are well defined in the long term conditions and end of life models; the generic team in each locality will be multi agency, integrated and coordinated generic teams that would deliver care across the last year of a person's life, providing support and care to patients and carers. These teams would also be part of the LTC and Frail older person's new delivery model designs.

4.8.10 We would see these teams as being based around the GP and nursing and social workforce in the community. We currently have practice integrated care teams in 25 practices in Central Manchester and would aim for the teams to built up around this model. The teams will need to be flexible enough to respond to local need and circumstances in terms of case loads and skills sets. We would build the team linking into the 24/7 district nurses enabling a 24/7 and re-ablement service offer approach.

4.8.11 The teams role as we see it would be to identify those people who on their journey to frailty. The team would provide a key worker for each person. The key worker would manage the interface between primary and secondary care and the expectations of patients and carers. It may be that there are known key workers that are appropriate for each stage of the persons journey – those most known they should not change on the setting of the care but the key worker in the generic team would provide the link.

4.8.12 The teams would work within a framework that would look at all the services and projects currently in this area and look to eliminate duplication, effectiveness and efficiency across the current services and projects

4.8.13 Information about the person that is accessible to each service in the NDM, e.g. when a person enters a hospital the appropriate key worker is called to co ordinate the care package. A key worker who will provide a care plan early in the journey and anticipates crisis situation that can travel with the patient regardless of the setting care is provided in

4.8.14 The team will be able to access clear referral systems that are linked to the specialist team and have a single shared assessment and plan. Information will be shared across interfaces including Out of Hours and NWAS. There will need to be an understanding of skills and knowledge between the generic and specialist teams to ensure continuity of care across the interface

4.8.15 The changing role of GPs and the primary care commissioning strategy would be central to the generic team design.

4.8.16 Our vision for the frail elderly and adults with dementia, for the community integrated care element, is best described by five existing services:

1) Primary integrated care teams (PICT)
2) Integrated homecare pathway (including reablement) and intermediate care beds providing step up and step down care
3) CMFT Community services integrated 5 year strategy.
4) Manchester Mental Health Trust Dementia Directory of services

4.9 Specialist proactive care teams – developing and supporting ambition

4.9.1 As the frail older person progresses on their journey through frailty, they will accumulate illness, which is likely to necessitate input of acute services. Ensuring the person is known and that their complex baseline is understood before arrival is important in order to ensure the individual's need can managed be appropriately

4.9.2 Where ever possible the older person is better cared for in the home (or their normal place of residence). In our vision we will be able to, if the person calls 999, NWAS will have the ability to divert, following the care plan, to alternative service to support the individual. If the person presents at Accident and Emergency Department, turn around and support the person to get back home without being admitted. There will be occasions when the need for acute medical attention is the priority; being seen as early as possible by Consultant Geriatrician is fundamental to ensuring the appropriate diagnostic set and care planning is undertaken. When the patient, if it is appropriate and all other avenues to avoid admission have been exhausted, is admitted the

team support the frail older person, or person with dementia to avoid moving them around the hospital and ensure the patient ends up in the appropriate setting as quickly as possible.

4.9.3 Planning for discharge starts before admission, and is supported by the clear understanding of the patient's baseline and needs of her/his carers. Our vision would see a care conversation between the patient/carer, hospital consultant and the specialist and generic team in community to ensure the patient "gets the best deal". With access to a co-ordinate team, the patient/carer and hospital teams can consider a much wider range of ways of support the family. The "best deal" is one that balances the person's needs, the carers, clinical and social needs within the constraints of the system

4.9.4 The specialist team input to the frail elderly and adults with dementia would include existing specialist nursing, mental health and social care, and carer expert teams as well as the input from the specialist proactive elderly care team.

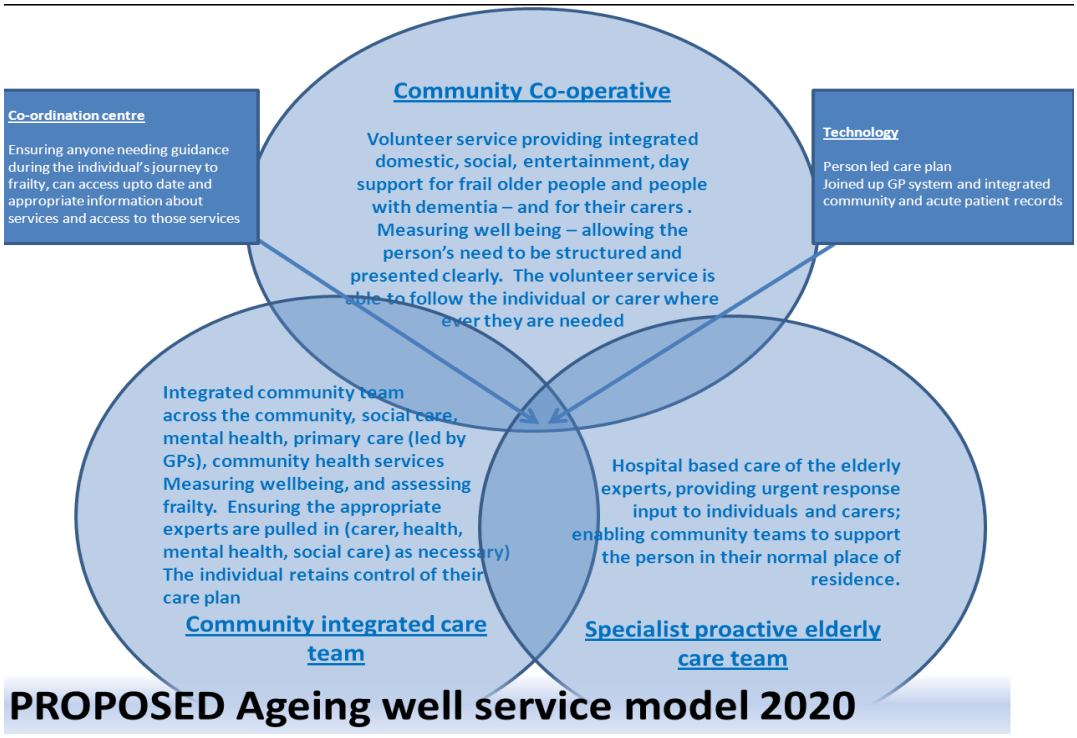
- Medical consultant that worked across the interface of the hospital and community providing leadership and integrated care
- specialist nursing and social work teams
- specialist therapy teams providing rehabilitation in a persons own home and community settings 72 hour crisis response
- In reach/outreach step up step down

4.9.5 The team would operate under one framework by which to avoid duplication, and increase effectiveness and efficiency across the current services and projects.

4.9.6 Our vision for the frail elderly and adults with dementia, for the community integrated care element, is best described by four existing services:

1) Observational Medical Unit and GP Assessment Unit – providing opportunities to admit to assess and discharge in less than one day
2) Complex discharge team including CHC assessment process – owning the CHC assessment process on behalf of the patient, to ensure an outcome is achieved as early as possible
3) Home from hospital follow-up call (voluntary sector)
4) Liaison in Later Years Service (LILY – dementia psychiatric assessment)

4.9.7 To illustrate the proposed model of care:



4.10 Future service summary:

4.10.1 Commissioned and co-ordinated volunteer structure and community hubs: Developed in each four localities within central Manchester providing integrated domestic, social, community events, day care, mentoring and "neighbourly support" services to follow individuals in and out of hospital. The purpose of this team is to maximise the ambition of the individual and carer.

4.10.2 Co-ordination centre: To own and ensure the broad range of services across all providers in the City are understood and can advise care providers in the range of options available. The purpose of this team is to ensure the individual and carer achieve the "best deal" possible.

4.10.3 Generic / integrated care team: Team based around the GP; Provides wellness measure for early stages of the frailty journey; provide comprehensive frailty / dementia assessments where appropriate. The purpose of this team is to increase the length of time the individual and carer can be managed at home or their normal place of residence.

4.10.4 Specialist community team: The frail older person and adult with dementia requires, in the community, a range of specialist input to support their long term condition, mental health and needs

4.10.5 Proactive elderly care team: Hospital based team that provides expert diagnostic and management of acute illness and frailty outreach. Identifying the patient early enough to prevent admission (where it is appropriate); build confidence and trust across the generic and specialist teams to proactively keep patients from hospital, and ensure the individual can return home as early as is practicable. The purpose of this team is to ensure, when complex acute needs present the person receives an appropriate diagnostic and care plan that is aligned to their baseline.

4.11 The model components and Resources

4.11.1 The existing resources are identified above; the table below highlights areas of change and further discussion

4.12 Priorities for 2014/15

4.12.1 The following initial actions are for April 14 and beyond and are dependent on there being agreement to the initial new delivery model, and the issue of transitional resources being addressed. Thus is also an initial high level view and we would want to build on this as we go forward in the following weeks.

4.12.2 Community Cooperative

1) Establish a framework for co-production and design of the new delivery model between 2014-2020 by patients, carers, the community and practitioners. Explore this being shared with other new delivery models in Central and possibly across the city.
2) Support the community co-operative model to become established in central Manchester (based on the Age Concern Manchester, Crossacres model)
3) Support the volunteer networks (carers and others) to continue to provide a robust team providing consistent delivery of care across the City

4.12.3 Community integrated (generic) teams

4) Identify and implement frail assessment tools. Three types 1) person led assessment of wellness; which precedes 2) the frail assessment/dementia tool (short) when a more formal assessment of frailty is needed); and 3) frail assessment/dementia tool (long) when the level of need is acute
5) Develop a model to allow one person leads and co-ordinates care (and that can be the person themselves, or carers)
6) Co-ordination centre offering support to patients/carers and all care provides to identify the range of potential care and support options available supporting the identification of the “best deal” for the individual and their carer

7) Design for a co ordination centre across all the cohorts in LTC, EoL and frail older people to be drawn up to enable a simple number and response for patients, carers and practitioners to co ordinate a person's care around the system – and identification of the "best deal" for the individual and carer. Explore whether this can be shared wider than central if needed.
8) Understand the current PICT team development in order to support the higher volume/demand for services
9) Agreeing the design of the generic team which is built upon the current practice integrated care teams. Establish the changes needed to enable a patient and carer to have a key worker as the main support through the 2 year programme
10) Need to agree phased implementation of the generic model possibly through one locality at a time.

4.12.4 Specialist proactive elderly care teams

11) Continue to fund the Liaison in Later years (model) funding supporting the assessment and diagnosis of dementia for the frail elderly
12) Increasing Geriatrician cover and senior nursing input to support early and easier access to Care of the Elderly experts whilst in the hospital.
13) Expand the home from hospital service to provide urgent and full response

4.12.5 Other proposals

14) Technology solution to instantly connect the person, at ED or any other service to one of the nominated members of the generic/specialist team (via Skype for example).
15) Pre alliance contract being enacted across the main providers in the new delivery model and also acknowledge in those that are not in the pre alliance and how they will be brought into the structure.

Section 5 - Programme Leadership

5.1.1 This new delivery model design is a very ambitious programme of work to bring together numerous organisations and co produce a new delivery model over the next 7 years that will start to be implemented from April 14. Therefore there will need to be a governance structure that has within it a programme board and subsequent teams with skills that can deliver the change not only in the service redesign but the supporting infrastructure.

Estates

5.1.2 We will need to look at the beds available within Central Manchester as currently there are no hospice beds in the city – this will mean assessing the need for support to people in the own homes, care homes and whether we will need to other beds in the community.

5.1.3 The Central Manchester area has three major parallel road systems to consider, Princess Parkway, Oxford Road and Stockport Road. This is important in terms of access for both staff and patients. Congestion is an issue and travelling time can affect efficiency and cost.

5.1.4 The growth of the population in the city centre has increased over recent years with a generally young population without many health resources. The city centre is historically part of North CCG but many of the urgent admission and ambulance activity that arrives at CMFT originates in the city centre.

5.1.5 The new GP provider organisation in Central Manchester is divided into four localities although it is unclear what their estates strategy is.

5.1.6 Whilst co location of different services does not in itself lead to integration it is a major factor in facilitating new ways of working. Integration should be based on the care model addressing the patient need and should not be just across professional boundaries but across organisations. Both Manchester City Council and CMFT are developing mobile working strategies that will promote more opportunities for teams to work together.

5.1.7 A hub and spoke model across organisations, as we progress new delivery model designs, would be a consideration for the estates domain.

5.1.8 We will also need to establish whether it is feasible to bring people together in terms being co-located across the city – space, facilities, parking.

Workforce

5.1.9 If we are to undertake this new delivery model design there is a considerable workforce component across all agencies and carers in terms of:

- bringing teams together – virtually and to co locate
- redesign of teams – roles and skill
- joint training to change culture and raise standards and awareness
- mobile working
- behaviour change

Information

5.1.10 The issue of information both in terms of being able to access information and using information technology to delivery care will be a crucial if the new delivery model is implemented. We would need to

- Access to records across the interface
- Mobile working to enable the delivery of care in people homes
- The production of technology to enable carers ad patients to remain in their own homes and in some cases deliver their own care

- Use of assistive technology to facilitate independence

Finance and contracts

5.1.11 The cost benefit analysis has been addressed earlier in the document. However there is a considerable amount of work to be undertaken to ensure that the providers working together in a pre alliance contract, can trust each other to behave in a manner that will achieve the outcomes needed or the new delivery model.

Section Six: Evaluation and Metrics

6.1 Metrics

6.1.1 By changing our model we believe that more people will age well, achieve their ambitions in later years, and live in their own home or normal place of residence for longer, and need fewer admissions to Hospital. Furthermore the well being and needs of the carers will also be supported.

6.1.2 The Living Longer Living Better programme of work has high level goals which are

- Add years and quality to life (choice of measures in next column)
- Help people to live more independently
- Improve health and social care outcomes in early years (0-4 years) in order to improve school readiness
- Reduce cost & volume of care in hospital
- Increase spend and volume of out of hospital services
- Improve experience of patients/carers at end of life
- Improve patient/carer experience of secondary care (inpatient and A&E)
- Improve patient/carer experience of primary care (general practice, dental services, out of hours)
- Improve patient/carer experience of community health services
- Improve patient/carer experience of social care / support services

6.1.3 When developing metrics for our new model we would want to be clear on:

- Why the indicator is important in the context of the new delivery model e.g. clinically or financially
- How we would expect the NDM to have an impact on this measure
- What impact would you expect the NDM to have on this measure and on the corresponding balancing measures.

6.1.4 The metrics we would put in place across our system to enable this to happen are:

- AE attendances down

- Admission to wards 45/46, 30 and 32 reduced
- Out patients reduced although may support reduced admissions
- Lengths of stay
- Readmissions
- Admissions to residential homes
- Admissions to nursing homes
- NWAS transfers

6.1.5 These will be balanced by an increase in

- reablement services
- identification of people in the *cohort* by general practice
- activity in services in community settings
- people in the identified group who have a key workers
- people in the identified group who have a care plan
- carers in the indentified group who are known and involved in the care plan

6.1.6 Patient, carer and practitioner experience metrics need to be identified from ones that have been used in previous integrated projects.

- Pain and symptoms are managed by a multidisciplinary team.
- Health and wellbeing is optimised during the last year of life.
- There is a well trained and confident workforce in Central Manchester
- Effective partnership working to deliver excellent care that meets the patient/carer needs.
- Patients and families will matter and feel that they matter.
- Emotional and practical support is available.
- Care is co-ordinated across organisational boundaries.
- Patients will be supported in their preferred choice of place of death
- The service will be available to all on the basis of need not diagnosis.

Section 7 - Conclusion and Recommendation

7.1.1 The document is an initial high level design for a new delivery model for long term conditions in Central Manchester. It has considered the emerging commissioner care model and started the design process around 5 specific new delivery model components across a range of providers.

7.1.2 If the initial design was accepted there are still significant issues that will need to be worked through including the financial and contractual envelopes and the detail of how the model would be implemented and over what time scale.

7.1.3 Our understanding is that there is a considerable amount of work to be undertaken between now and the end of March with specific decision making points being:

- 20th December – Central Provider Partnership Board discussion as to whether to agree the initial design. If approved:
- 20th December design to be sent to the City Wide Living Longer Living Better team for inclusion in a January HWB Executive paper

- 8th January HWB Executive meets to discuss the programme
- 22nd January CICB meets to discuss and is asked to approve the initial new delivery model designs
- February and March HWB Executive, CPPB, CICB and HWB meetings to progress the programme of work.

7.2 Recommendation

7.2.1 The Board is asked to:

2. Accept the paper and it being sent to the city wide team

3. Acknowledge the time line and the progression of the paper

5. Acknowledge the work that needs to be undertaken if the new delivery models are to progress and actions needed between now and the end of March

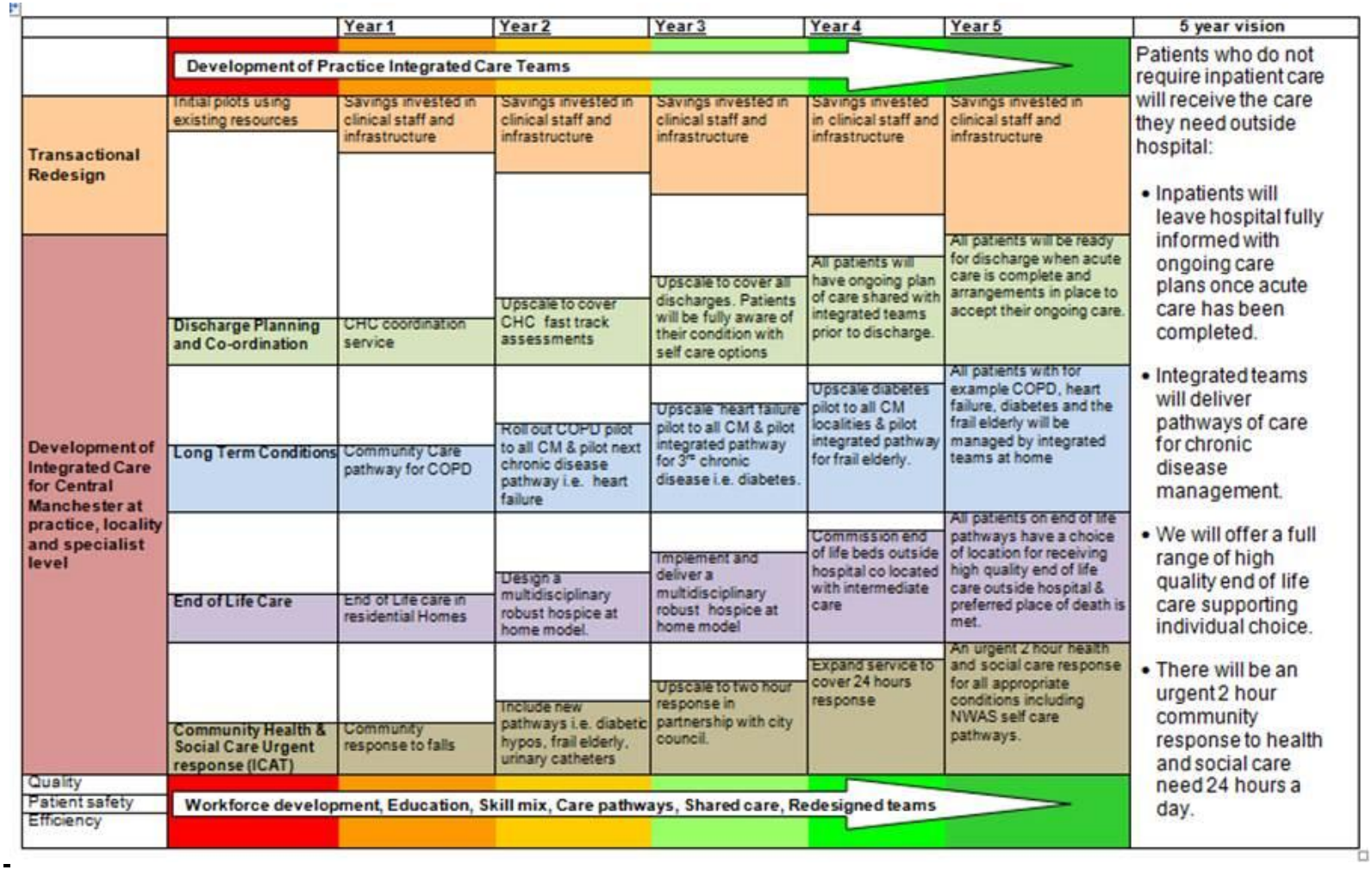
Appendix 1:

David Evans, Head of Quality and Performance, Central Manchester Foundation Trust. Supported by:

Name	Organisation
Dave Williams	Manchester Carers Forum
Jackie	Manchester Carers Forum
Diane Eaton	Manchester City Council
Caroline Hourigan	Manchester City Council
Jane Barcoe	Age Concern Manchester
Jacqueline Thompson	CMFT
Dr Paul Bannister	CMFT
Chris Lamb	CMFT
John McGrath	Manchester Mental Health and Social Care Trust
Stefanie Cain	Central Manchester CCG
Dr Dave McConalogue	Manchester City Council
Sara Radcliffe	CMFT
Vish Mehra	Central Manchester GPPO

Living Longer, Living Better – New Delivery Model Design
Central Manchester

Appendix 2: Adult and Specialist Community Services 5 year plan



Appendix 3:Supporting Information

The following supporting information is available at request from Katrina Devall. If you would like a copy of any of the documents below, please email katrina.devall@cmft.nhs.uk.

1. **Health and Wellbeing Board reports:**

Living Longer Living Better Blue Print, March 2013
Living Longer Living Better Strategic Outline Case (Part A and B), July 2013
Living Longer Living Better Business Case, November 2013

2. **Commissioner Care Models:**

Adults with Long Term Conditions
End of Life for Adults and Children
Frail Older Adults and Adults with Dementia

3. **Central Manchester New Delivery Models:**

New Delivery Model for End of Life Care
New Delivery Model for Long Term Conditions

An Integrated Adults Long Term Conditions New Delivery Model Design for Central Manchester

An Integrated Adults Long Term Conditions New Delivery Model Central Manchester Care System

Author:

Sara Radcliffe: Programme Director for Integrating Care, CMFT, and member of the city wide leadership team for Living Longer Living Better (LLLB).

Version 6 of the Document agreed by Central Manchester Provider Partnership Board on 20th December 2013.

Name	Organisation
Gill Heaton	CMFT
Dave Williams	Manchester Carers Forum
David Beckett	Go to Doc
Diane Eaton	Manchester City Council
Ed Dyson	Central Manchester CCG
Ivan Benett	Central Manchester CCG
Jon Simpson	CMFT
Mark Edwards	CMFT
Mike Wild	MACC
Neil Walbran	Health Watch Manchester
Sara Radcliffe	CMFT
David Ratcliffe	NWAS
Stuart Hatton	Manchester Mental Health and Social Care Trust
Vish Mehra	Central Manchester GPPO

Executive Summary

This document has been written as a result of people from 7 organisations working together over a two month period, to create a high level design for the new delivery model for people with long term conditions in Central Manchester.

It is a response to Manchester's Living Longer Living Better Integrated Care Programme and has been shaped by the emerging commissioner care model and profiles.

We have taken at the heart of the design the premise that Mrs Pankhurst, her carer, her family and the community she lives in are the main focal point. That any design we deliver should be achieved through partnership and have a changed in focus to how we deliver care in the community.

We have broken our design into five components which we believe make up a new delivery model.

- **Coproduction** with patients, carers and the community. A model designed with the people and communities that will use it.

- **Coordination** a central service point providing an overview and point of contact for all services in the design to enable the model to be delivered across multiple providers.

- **Generic multidisciplinary teams** in each locality that can care for a person throughout a persons long term condition(s)

- **Specialist team(s)** that will be able to give coordinated care to a patient and their carer in the community

- **Carer Support** a physical and virtual service giving advice and information with identification of the carer and their needs at a generic team level. When we refer to carers in the document we are referring to unpaid carers.

Our new delivery model is built upon the work that Central Manchester has been undertaking over the last three years under the framework of the Central Integrated Care Board and other partnership initiatives that have developed. However, we feel that if we are to achieve the outcomes of the care model we need to increase the scale and pace of change whilst eliminating duplication.

For the coming year we have listed actions from April including the development of the coproduction approach, co-ordination centre, generic and specialist teams.

We also recognise that any new delivery model will need to have a secure governance framework and infrastructure surrounding it. This would include areas such as finance and contracting, estates, information and workforce development. All of which will need to be programme managed through a complex and challenging environment.

Contents Page

Section 1: context

1.1 Introduction

1.1.1 The paper describes the new delivery model design for adults with a long term condition (aged 18+), who are registered with a GP in Central Manchester, and their carers. It has been produced by a number of providers working together in Central Manchester and is a response to the Manchester Commissioners (3 Clinical Commissioning Groups and Manchester City Council) Living Longer Living Better (LLLB) care model for long term conditions.

1.1.2 We understand that this is not a final product but the start of a process by which we, the Central Manchester system, can work together to achieve a vision of care for 2020. A vision which is a coordinated response to a patient and carer's need and is delivered as close to their home as possible.

1.1.3 It is recognised that this is an ambitious programme of work and understand that there is still a great amount of work to be done in terms of quantifying what this means - resources and activity. We also acknowledge the complexity for the commissioners, the need to be able to work with providers differently in order to commission this model of care, over the next 7 years, to achieve the 2020 vision.

1.1.4 We also acknowledge that there is a large amount of work to be undertaken in areas such as workforce, estates and information. This is needed if the model is to be underpinned and delivered in the community in an effective and sustainable manner.

1.1.5 However, we do believe that what we have outlined is the start of a new delivery model design that can achieve lasting change.

1.2 Design Process and Need for Change

1.2.1 Over the last seven weeks there have been 2 workshops and two design meetings with individuals from a range of organisations who provide services to Central Manchester patients, who have a long term condition, and their carers. The people who have been involved are outlined in appendix one.

1.2.2 This document has been developed from the meetings and workshops. It is our first iteration for what we hope will be an ongoing process of improvement and design to create a new delivery model. We also believe that this new delivery model should be seen as a part of a wider system change that includes people at the end of life and frail older people and adults with dementia.

1.2.3 Most people do not define themselves by a medical label and many have more than one long term condition, therefore we need to see all the new delivery models as being around the person and therefore sharing many design elements.

1.2.4 A customer and patient engagement event was held in December to talk to patients, their families and carers around the key themes in the care model.

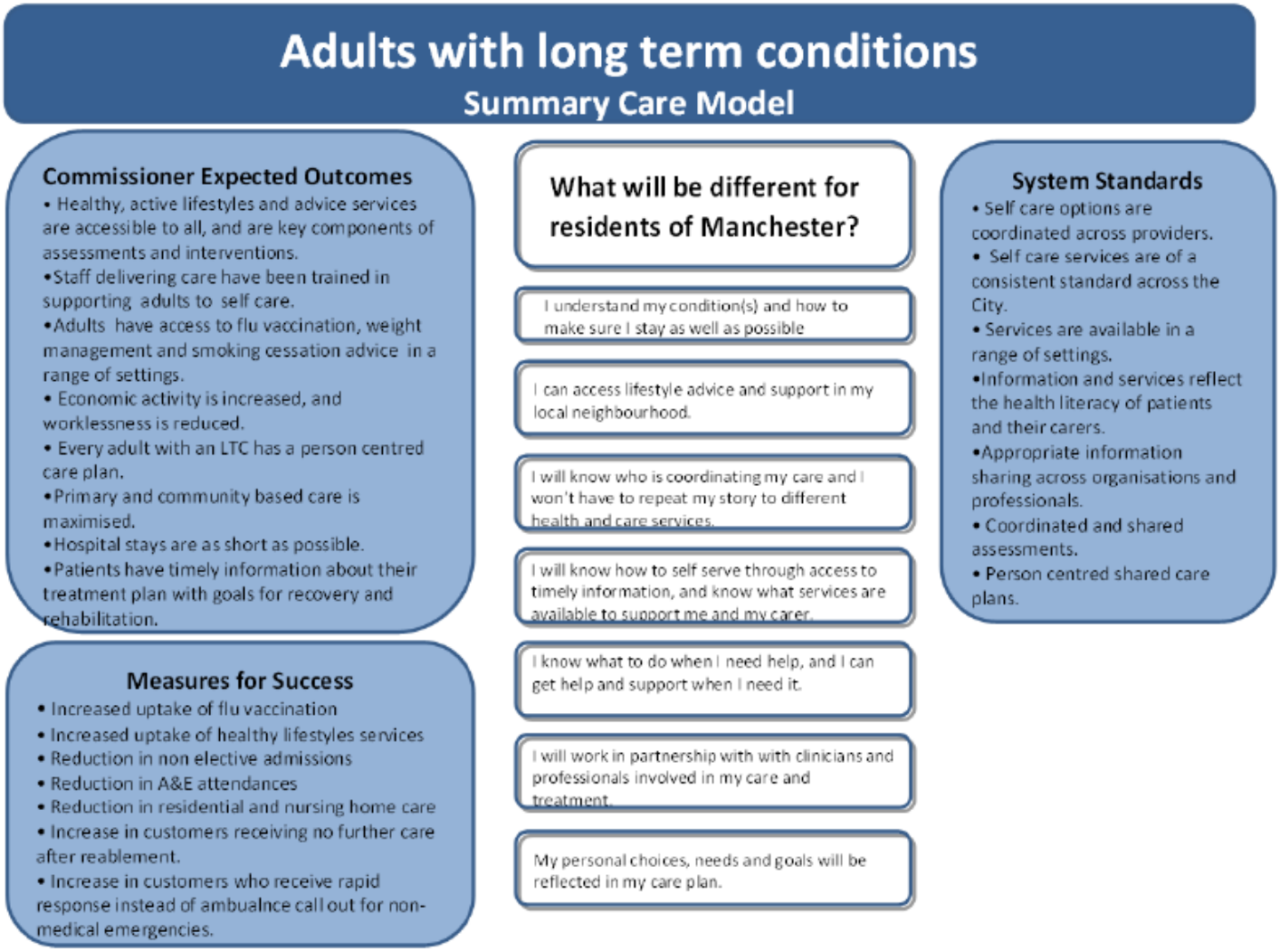
1.2.5 Over 63 people attended and 45 would like to continue to be engaged in how we go forward. The event was based around asking questions on the present and future care model and some specific issues are contained in the later section on coproduction.

Section 2 – Commissioning Care Model

2.1 Long Term Conditions Care Model

2.1.1 This design is a response to the LLLB adults long term conditions care model produced by Manchester Commissioners. As a group of providers we have come together to create a joined up, co-ordinated design which we believe will achieve the outcomes, benefits and standards as identified below.

Diagram 1: LLLB Adults Long Term Conditions Care Model Overview



2.1.2 The NDM we are designing we feel will address the care model as outlined in the summary table above. However there is the need to identify what we are able to do in our present resource envelope as a group of providers, and what we may need transitional resources to achieve. The timeline is crucial as the design we are proposing is one with a 2020 date and implementation will need to take place over the next 7 years in a phased way, within the identified resource envelope and activity/resource shift requirements.

2.1.3 There are also other issues which we will want to discuss with commissioners as we develop the new delivery model such as:

- The need to be specific about the measurable goals for those patients who are already living with LTC, and those people who will develop LTC in the future – the goals of these two population groups may be very different
- The cultural change that is needed to achieve a lasting change in perception and also the language that we use in relation to this group of people
- The need to explore further the issue of recovery as outlined in care model, as some patients will not recover but need to live with their LTC for the rest for their lives

2.2 Commissioned Shift

2.2.1 The following is a draft diagram, objectives and targets produced by the commissioners to look at shift for people who may receive continuing health care and personalised care. Further refinement will continue but this is a good starting point by which the new delivery model can begin to be designed.

2.2.2 Unfortunately the objectives and targets for LTC were not available for the first workshop and our subsequent design meetings, so were not included in the design modelling. However, we do recognise that we will need to discuss this with our commissioners at a later date.

Diagram 2: NHS CHC and Personalised Care Summary

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Impact on other parts of the system i.e. MH, LD, CHC	1. Access to primary care for the population groups will include: - All people with complex care needs - Mental health needs - Continuing Healthcare (CHC) - Learning Disabilities (LD) - Chronic Disease Pathways 2. Access to social care and housing options including equipment 3. Brokerage support for the delivery of PHBs 4. Accountancy services for the delivery of PHBs
Clinical Rationale	Health and social care services working together to provide better support at home and earlier treatment in a community setting prevented 2,000 fewer patients needing emergency care in hospital or a care home. The personal health budget pilot evaluation was published in November 2012. The national evaluation found that personal health budgets improved people's quality of life and reflected the local findings in Manchester. The findings showed that: • The amount of times people had to attend hospital decreased overall. • People had a significant improvement in their care –related quality of life and psychological wellbeing .The health 'status' stayed the same • Benefits where more marked where people had higher levels of need • Personal health budgets also worked better where people were given more choice and control, both over what they bought and how they received the budget .In contrast where the pilot site imposed a lot of restrictions, personal health budgets tended to worsen peoples outcomes • People reported positive impacts of their personal health budgets for themselves and for their family members • They also talked about the change in their relationship with health professionals • Family careers were more likely to report a better quality of life and perceived health than careers of people in the control group. If half of the people eligible for NHS Continuing Healthcare chose to take the offer of a budget, this could imply a potential saving of around £90
Impact from a GM Perspective	Economies of Scale across GM Services such as brokerage, equipment and accountancy services

2.3 CHC and Personalised Care Targets and Objectives

2.3.1 Anyone who is eligible for NHS CHC will be offered a personal care plan by 2014/15. In 2013/14 we hope to offer care plans to 75% of such patients. Eligible patients include anyone with complex or continuing care needs, mental health patients and those with chronic diseases.

2.3.2 The same people should be made aware of their right to a personal health budget. Again we aim to tell 75% of patients in 2013/14 and 100% in 2014/15.

2.3.3 The same numbers apply to the idea that everyone should only have to tell their story once. This will help to tackle issues at an earlier stage, rather than relying on the more expensive crisis services. This is particularly relevant for older people with long term conditions and families with complex needs.

2.3.4 We aim to put patients at the heart of care. This will be measure by the new NICE Quality standard. Providers will introduce the 'friends and family' test, as well as patient shadowing, in order to judge user experience.

2.3.5 Patients will also be offered the right to 'diarise' their journey, giving them more information and more control of their care. The targets are 85% in 2013/14, rising to 90% the year after and 100% in 2015/16.

2.3.6 Patient choice is an important goal of ours. We want 100% of patients to be able to choose the date and time of their appointments, as well as choosing their provider, site and specialist. This is to be completed by 2014/15.

2.3.7 We also want assessments to include support on self-management in primary and secondary care for a range of long term conditions. The plans should be established and reviewed in 2014, and introduced in 2015.

2.3.8 In the workshops and design team meetings we have accepted that these objectives and targets for CHC and personalised care are a good starting point, but we will need to have more discussion to ascertain what this will mean in terms of how, timescale, resource and measurement etc.

2.4 Financial profiling

2.4.1 To support the financial assessment of the new delivery models being developed under the LLLB programme, a finance and contracting work-stream has been established with representation from all eight partner organisations across Manchester. From December 2013 to March 2014, the workstream will focus upon:

- **Financial context and goal setting**: agreeing commissioners' affordability and cost envelope - based on the agreed scope of services, current spending baselines, assumptions about investments, stretching efficiency goals, phasing of implementation and a shared understanding of transitional support costs.

- **Stakeholder engagement and governance**: shared financial planning methodologies and assumptions across the eight partners, linked closely with the LLLB programme to ensure appropriate governance.

- **Financial modelling and business case development (Cost Benefit Analysis):** testing the desired impact of care models in the context of the LLLB financial model to understand the cost implications of changes in demand and service provision. This is a crucial step in terms of developing the business cases that will be required to

secure investment in 2014/15 and beyond as integration plans expand across wider population groups. The costs of new delivery models must be affordable within the financial context.

- **Contract development:** exploring the scope, risks, benefits and pace of implementation for alternative models of contracting to reflect the new delivery models.

- **Better Care Fund:** describing and agreeing the financial implications of the LLLB programme and its impact upon partners, in particular, the acute sector, within the Better Care Fund plan (including agreeing performance baselines against the four national measures that are linked to payment).

2.5 Pre Alliance Contract

2.5.1 In addition to the cost benefit analysis, partners in Central Manchester's health and social care system are working to develop an Alliance contract around urgent care services. The aim of this is to align goals between providers and commissioners, to collectively reward achievement of goals and to support a movement of resource to increase out of hospital care. The full alliance will commence in 2015 but a pre-alliance contract is planned for 2014 which will incorporate these same aims.

2.5.2 The relevance to the implementation of new delivery models is in two parts:

1. The pre-alliance will have a performance related pay framework which includes both implementation of New Delivery Model and achievement of outcome measures.

2. The pre-alliance plans to have the means by which money can move within the overall contract to support investment planning.

2.5.3 These are designed to support and enable the development and resourcing of New Delivery Models for LLLB. Organisations are now working together to put in place this contract arrangement for April 2014.

2.6 Provider response to the commissioning profiles

2.6.1 As a group of providers we have considered the commissioning profiles as they currently exist. We believe we can work together to produce a joined up, co-ordinated design which we believe will achieve the outcomes, benefits and standards as identified above. It is our wish to include mental ill health as a long term condition.

2.6.2 However there are issues that need to be considered:

2.6.3 We will need to explore in more detail the objectives and targets to ensure that they are agreed by providers and we can be confident not only of delivering them but them being understood and measured.

2.6.4 We are aware that changing services cannot be achieved overnight and there needs to be a period of development, evaluation and shift to enable sustainability. Therefore the timeline in which the dew delivery model is implemented is crucial and will need to be phased in and delivered over a number of years to achieve the full model.

2.6.5 There is the issue of understanding the current resource envelope for this care model across providers, and any future resource envelope that we need to work within. Without this information the new delivery model we have put forward is un costed. Therefore it will need to be reassessed in the light of the work of the financial workstream outlined above.

2.6.6 There is also the issue that the new delivery models will, by their nature, cross many providers and therefore there is the issue of the providers understanding and agreeing the joint targets and objectives that they will need to achieve together.

2.6.7 We also feel that there is significant implications for the new delivery models in relation to the Care and Support Bill which aims to prevent and reduce needs, put people in control of their own care and clarify entitlements to care and support. The bill will come into effect from April 2014 and will be fully implemented in Manchester by April 2015.

2.6.8 From April 2013, the local authority will be responsible for using national minimum eligibility criteria to identify any people who have an unmet care need, completing initial assessments to establish whether people are eligible for care, completing financial assessments to determine who will pay for the care and providing personalised care and support plans to people and carers where required. The bill also gives legal entitlement for an individual to receive a personal budget which outlines the total cost of providing their agreed care plan. These duties will apply to all people irrespective of whether they are funded by the local authority or self-funded.

2.6.9 The bill gives the same rights to carers as those given to the people they care for. Local authorities will have a duty to identify carers with unmet needs and provide them with assessments and support plans.

2.6.10 There are significant financial implications from the bill which will need to be taken into consideration. The financial impact cannot currently be reliably modelled and there is a very high level of uncertainty and risk around the financial implications of the bill and its impact on a new delivery model.

Section 3 – Current Provision

3.1 Current Services

3.1.1 In this section we have worked as a collection of organisations to assemble what we view is the current provision profile. However we only have the knowledge of the people in the room at the time, and therefore there may be other services that are commissioned, or pilots being undertaken, that we are not aware of.

3.1.2 The Central Manchester system has a strong foundation of integrated working across a range of providers. This is both under the framework of the Central Integrated Care Board and outside it. There has been particular success in the last two years in implementing practice integrated care teams in 25 practices and a range of intermediate care services. These have formed what is labelled the "five year plan" (appendix 2) and much of the design in this document is predicated on these developments underpinning the future new delivery model.

3.1.3 We are also at a very early stage of working together in a coproduction methodology as a provider group. It is comfortable to look at change for the future and acceptable to look at current issues - it is more difficult when we need to share activity, data or financial information which may be sensitive. We have numerous business cases across the organisations for various parts of the new delivery model. These are known but we have not shared them until we are clear on the process from April to implement parts of the NDM.

3.1.4 Therefore, at present, we have kept this section at a high level.

Table 1: A summary of the current services which will be included and impacted by the new delivery model for Long Term Conditions

Current Services in the NDM (Category A)	Impacted Services (Category B)
– **GP core services** – **GP enhanced services** – **Central Manchester - Demonstrator site projects** – **Go to Doc OOH** – **CCG Medicines Management Team** – **Community Pharmacy** – **Community Services Medicines Management Team** – **CMFT Community services** – **CMFT Specialist Services** – **CMFT In-patient Services** – **Manchester Mental Health and Social Care Trust** – **Screening programmes** – **Services outside area eg UHSM, PAHT**	– A & E Departments – Primary care emergency centre – Hospital in-patient wards (adults) – Bed management teams – Discharge services – Clinical 'speciality teams' ie Renal, Cardiac, Respiratory, Cancers – Safeguarding teams – facilities management systems (portering etc) – Pharmacy – NWAS & Arriva – Infrastructure eg alerting

– **Services out of Withington Hospital for Central Manchester registered population** – **PPAG** – **ICATS** – **Age Concern Manchester** – **Manchester City Council** **Services directly delivered e.g:** – **Safeguarding Adults Team** – **Social Work** – **Specialist & Regional Social Work** – **Contact Centre** – **Emergency Duty SW Team** – **DOLS & MCA** – **Blue Badge Team** – **Carers Support** – **Equipment & Adaptations Service** – **Financial Support** – **Reablement** **Services commissioned e.g:** – **Community Support** – **Healthy Lifestyles** – **Home based support** – **Support services for mental health** – **Care Homes** – **Nursing Homes** – **Respite Care**	systems, pathology – Access to equipment

3.2 Long Term Conditions projects currently under the Central Integrated Care Board

3.2.1 The following are projects that have been implemented over the last two years or are in development as part of the integrated work of the CICB. The present profile is too fragmented and needs to be pulled into a new delivery model in order that we avoid duplication and enhance the effectiveness and efficiency of the services.

Table 2: A summary of current projects for Long Term Conditions under the Clinical Integrated Care Board

Telehealth for patients with heart failure	Choose Well Mobile Enabled Website	Acute medicine post admission patients	Vaccinations for Influenza & Pneumonia
Ascertainment and	Ascertainment and	Alternative to A&E	Practice Access -

optimisation with Diabetic Specialist Nursing	optimisation with Heart Failure Specialist Nursing	transfer by NWAS and GtD	Extended Hours DES
Ascertainment & optimisation of people with Atrial Fibrillation	Ascertainment & optimisation of people with CVD	Ascertainment & optimisation of people with Angina	Collaborative Primary Care Access
Ascertainment & optimisation of people with Chronic Kidney Disease	Heart Failure and Diabetes Enhanced Service for whole population	Asthma care for adults	Consultant Advice for Primary Care
Stroke Improvement	Community Pharmacy to increase patient education and support in managing LTC	Extended Primary Care Diabetic Service	Community Leg Circulation Service
Structured education programme for Type 2 diabetes	Extended Primary Care Heart Failure Service	Practice Integrated Care Teams across 25 practices	Adult Community Persistent Pain Service
Integrated Care Pathway for COPD (Gorton & Levenshulme locality)	Integrated Care Pathway for Heart Failure (Gorton & Levenshulme locality - only one practice)	End to end Ownership Model for continuing healthcare (CHC) assessment	Intermediate Care Assessment Team (ICAT)
IV and subcut fluid pilot (through community nursing)	CICB Medicine Management Projects		

3.3 Central Manchester CCG Demonstrator Site

3.3.1 In 2013, Central Manchester CCG successfully secured a Demonstrator Community Site bid which crosses all GP practices in Central Manchester. The expectation from the Greater Manchester Area Team is that projects will be able to demonstrate outcomes and benefits by April 2014. It is important that any new delivery model in Central Manchester takes into account the demonstrator site's projects and the possibilities of integration rather than duplication for future sustainability.

3.3.2 A summary of the projects is listed in the table below:

Table 3: A Summary of CCG Demonstrator Site Domains

Domain	Project	Rationale/model

Access *Improved access through collaborative working across practices extending availability and responsiveness.*	**Responsive Access**	Practices to adhere to quality standards of responsiveness to patient urgent and same day need.
	Primary care availability	Increase primary care available hours – to 8pm weekdays and 3 hours per day weekends, total 16 pw, through collaborative local arrangements.
	Primary care Homeless access	Specialist primary care through services at individual practices; potentially ensuring CCG wide co-ordination through GPPO.
Long term conditions *Improved Care through ensuring access to enhanced primary care services.*	**Long term conditions – Diabetes/HF**	To ensure population coverage of existing enhanced services for Heart failure and Diabetes.
	Patient education for people with LTC	Inhaler technique project through community pharmacy.
Patient Voice *Improving engagement and involvement of patients in their own care.*	**Dementia**	Population coverage for enhanced care for patients with Dementia
	Care Homes	Enhanced primary care medical and nursing services for patients in residential care and nursing homes.
Specialist primary care *Closing the gap between primary and secondary care through improving specialist primary care services.*	**Persistent pain management service**	Pilot service for patients who experience persistent pain lasting longer than 3 months. Commissioned from specialist acute provider, delivered through specialist primary care service.
	GP led in-reach	Provide additional medical input to patients admitted to CMFT, to support timely discharge and coordinated care in the community. Initially pilot practice, possible roll out following evaluation.
	Access to specialist consultant advice	Increase the number of routine Specialist Consultant Advice lines with main local acute provider, CMFT.

3.4 Issues with the Current Provision

3.4.1 The initial mapping of the current services has raised issues that will need to be addressed as we develop a new delivery model.

- The services and projects are currently fragmented across service and organisational boundaries, therefore raising possibilities of duplication and lack of effectiveness or efficiency.
- Care pathways do not support moving a patient quickly to their place of choice ie outreach from the acute sector or rapid care into patients' homes.

- There is no single point of access for patients/carers or practitioners to navigate the many services currently available. Therefore care becomes difficult to understand what's available and how to access it.
- The services are not seven days a week, or 24 hours a day, across the range provided, and because of fragmentation it is difficult to co ordinate such a response
- Continuity of care is variable, currently key workers change between care settings rather than a person having the key worker that knows them best regardless of where care is being delivered.
- There is no community developed model to foster a volunteer workforce and use the potential we have in areas such as CMFT volunteers service.
- There is limited facility for out of hours access to diagnostics, equipment or commissioning micro packages of care.

3.4.2 What is evident is that there are numerous services and projects that do need to be brought together. It is probably unreasonable to expect a patient, carer or practitioner to be able to co ordinate their way through so many services. Therefore, we need to make it simpler, have one point of call and clear co ordination to navigate an individual through the model.

3.4.3 We also need to be able to develop the workforce across the agencies including those in the public sector, the independent sector and carers. This will mean a change of culture and behaviour as to how we work in teams and in the community.

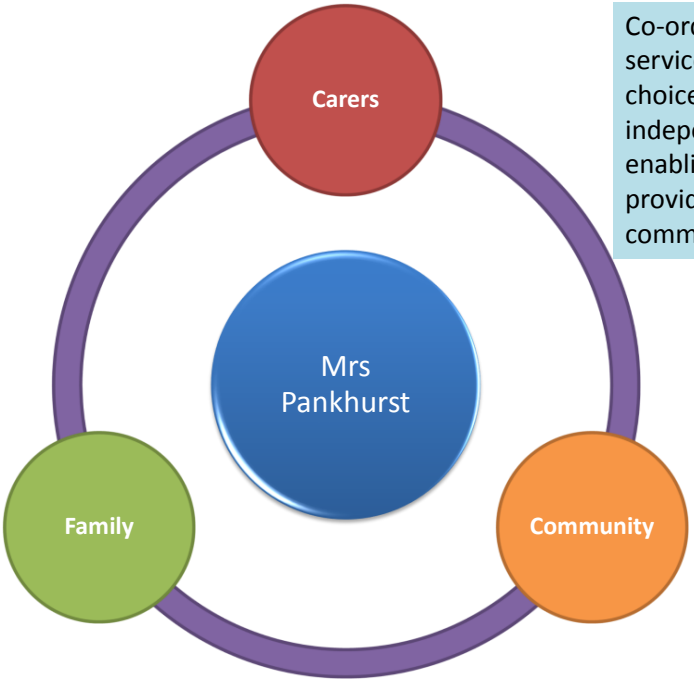
Section 4: New Delivery model for the future – 2020

4.1.1 As providers we totally endorse the need to see the person rather than the patient and to work with, involve and learn from the carer, the family and the community.

4.1.2 We endorse the symbol of Mrs Pankhurst for our new delivery models and the need to look at how the individual is central to all that we do, and their care is defined by their choices and their lives rather than our organisational structures.

Diagram 3: Coordinating Services around the person

The Person



Co-ordinated services creating choice, independence and enabling care to be provided in the community.

4.1.3 In exploring what a new delivery model design would mean for the registered adult population of Central Manchester, and the current providers that deliver services, we have assumed that by 2020 we will need to:

- Achieve the commissioned care model
- Deliver coordinated services, across providers
- Delivers a model predominantly in the community

We believe our NDM design will be delivered with

- Dignity and respect
- People will be known to the services, and services coordinated around them
- Physical and mental health wellbeing from the beginning
- In community surroundings, local delivery tailored to local need

4.2 Design Components

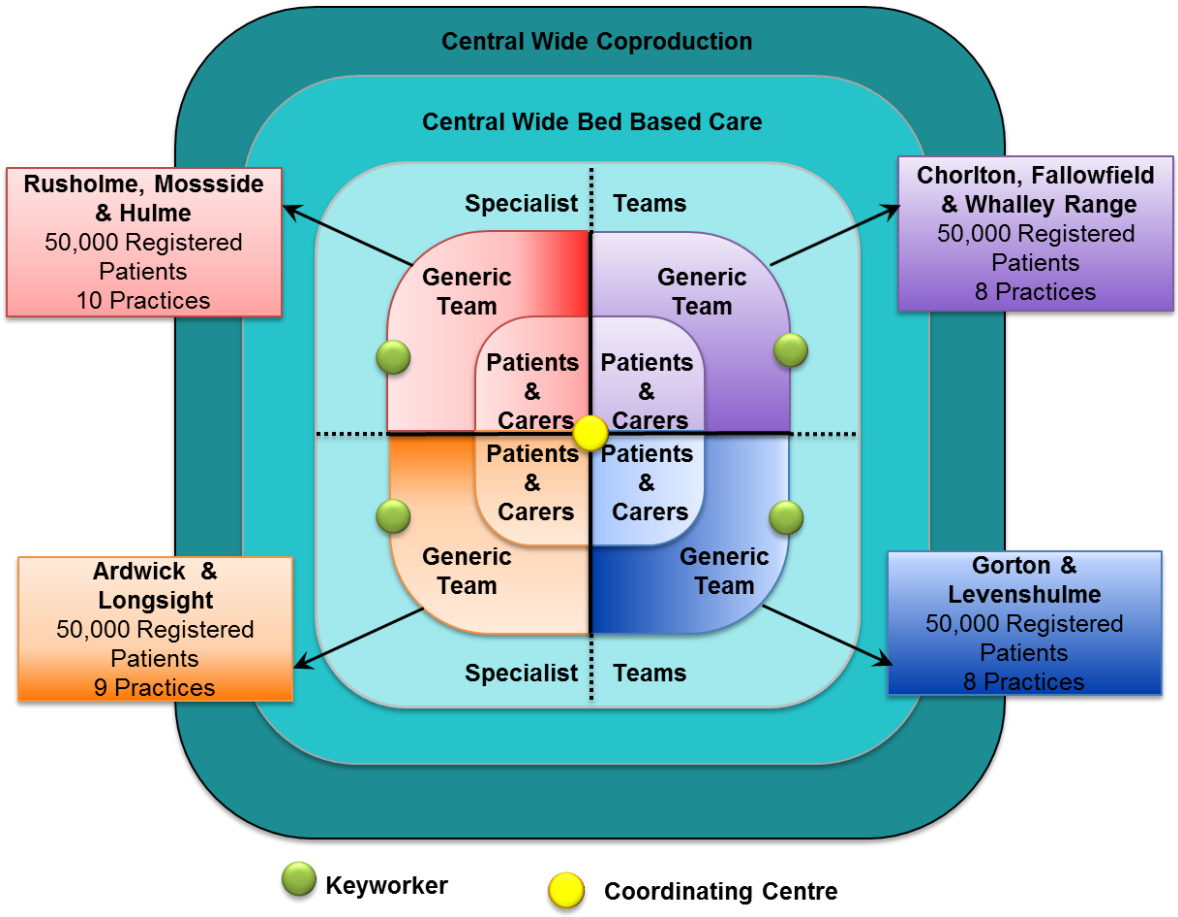
4.2.1 We have listed below five design components that we believe would make up our new delivery model. We believe that the new model should provide care wherever a person is in the community be that in their own home, a residential or a care home.

- **Coproduction** with patients, carers and the community. A model designed with the people and communities that will use it.

- **Coordination** a central service point providing an overview and point of contact for all services in the design to enable the model to be delivered across multiple providers.
- **Generic multi disciplinary teams** in each locality that can care for a person throughout their illness.
- **Specialist team(s)** that will be able to give co ordinate care to a patient and their carers in the community.
- **Carer Support** a physical and virtual service giving advice and information with identification of the carer and their needs at a generic team level.

4.2.2 The diagram below pictorially shows the components of our design:

Diagram 4: Components of the new delivery model for Long Term Conditions



4.2.3 As with any ambitious multi agency redesign, if agreed, the model will need to be further developed with partner organisations and the details of how, where and when worked through to enable pathways, teams, services and ultimately the model to work effectively.

4.2.3 The outlines below are high level descriptions of what we think should be developed.

4.3 Coproduction

4.3.1 This design is at a very early stage and we know that what we have in place in 2013 will not be what we will aim for in 2020. However one of the main areas that we feel we need to address is the ability to work with local communities in a way which enable us to co produce and design models for the future.

4.3.2 When designing a community owned and co produced model it may be that having a vision for 2020 is not far enough, we need to be designing a vision for those young people who may have LTCs in the future. Therefore the need for technological solutions and a need for a web and virtual presence should be central to the design.

4.3.3 If we are going to have a community owned model there is a need to assess who in the community would engage in designing, running and sustaining a model which is radically different from a centralised public sector owned model.

4.3.4 We want to build an infrastructure of community volunteer support which is the foundation block of our model design in 2020.

4.3.5 We believe coproduction should cross all new delivery models in Central Manchester and we would want to work with other so to see whether it could be a model for the whole of the city. In designing a new way of working together we would look to address the aspects of coproduction as outlined by the Social Care Institute for Excellence (2013), Co-production in social care, what it is and how to do it, http://www.scie.org.uk/.

4.3.6 Co-production is much more than just going out to consultation or co-creation where service users are involved in design. It is about seeing service users as equal partners with shared power and involving them in design, delivery, decision making and evaluation. To do this properly there will need to be radical changes to culture, structure and practice and this change will need to be accompanied by movement of resources to the people using services and frontline staff.

4.3.7 Coproduction will need to run through the culture of our health and social care partners and a shared understanding about what coproduction is,the principles for putting the approach into action and the expected benefits and outcomes will need to be agreed. In order to achieve this change organisations will need to develop a culture of being risk aware rather than risk averse.

4.3.8 The December event was a very first, small step in the process of working together. When asked at the December customer and patient event how well do you think health and social care services work for long term conditions now, the response was as follows:

- 1% Excellent
- 4% Good

- 45% Average
- 24% Poor
- 8 Very poor
- 6% don't know.

4.3.9 When asked after hearing about the new care model what do you think, the response was:

- 44% said it would improve things for patients and carers
- 17% said it would not make a difference for patients and carers
- 0% said it would make things worse for patients and carers
- 21% were not sure

4.3.10 Obviously we have a lot more work to do on how we work with patients and carers to develop these designs and implement appropriately. From the event in December we can be certain that we need to improve and we need to be able to communicate better what we are planning to do. We need to create a different culture and design platform where patients and carers and the community are co producing what the 2020 services will be.

4.3.11 Through coproduction we would hope that the design would consider what is based at a locality, sector or city level – what size and shape of delivery is the most effective and efficient. It would be aimed at the whole person – a model where people can age well and their physical and mental well being are understood. It would be culturally sensitive at a community level e.g. demographics and ethnicity both at a city, sector and locality level taken into account and a focus on where people live, work and congregate – rather than bringing people on an appointment basis into the institutional framework e.g. providing services in markets and mosques rather than medicalising the interaction. We should build upon community assets and see our design as playing a part in our city's economic activity.

4.4 Co-ordination Centre

4.4.1 There will need to be a co ordination function across the new delivery model so that the services are known and understood to patients, carers and practitioners. This will mean that this function, and therefore the model, can be accessed through a single point of contact – we are assuming this would be a one number gateway.

4.4.2 A single number would provide the caller with a person as the point of access to be able to signpost and navigate the practitioner, patient or carer through the menu of services as required.

4.4.3 We would expect this service to not only be able to give advice but if needed that the service would also be able to micro commission services for the patient, carer or practitioner services which are appropriate. For example this could be fore rapid

access to CHC, access to equipment, access to beds across the community, rapid access to volunteers, medicines or diagnostics.

4.4.4 We realise that this is a highly ambitious idea and we believe it should cross all the new delivery models and in some instances Manchester as a whole if appropriate. We believe that there is no future in organisations modelling their own gateways which produces numerous single numbers for people with multiple conditions. If we looked to combine our resources and expertise we could design and provide a highly skilled effective and responsive service.

4.5 Generic teams in the community

4.5.1 Integrated and coordinated generic teams in the four localities, providing support and care to patients and carers. These teams would also be part of the EoL and Frail older people and adults with dementia new delivery model so that the person is seen by a consistent team regardless of their condition.

4.5.2 We would see these teams as being based around the GP, nursing and social workforce in the community, but with other members as needed. We currently have practice integrated care teams in 25 practices in Central Manchester and would aim for teams to build upon this model. The teams would need to be flexible enough to respond to local need and circumstances in terms of case loads and skills sets.

4.5.3 We would want to build the model so that there is a co ordinated response to a person's needs through the a 24 hour period every day of the week.

4.5.4 The team's role, as we see it, would be to identify those people with a LTC. The team would provide a key worker for each person. The key worker would manage the interface between primary and secondary care and the expectations of patients and carers. At certain points it may be more appropriate for the key worker to be within a specialist team, but the generic team key worker would still be able to provide a point of reference and consistency.

4.5.5 The teams would work within a framework that would look at all the services and projects currently in this area, as well as primary care practitioners such as pharmacists and the independent sector. We would aim to eliminate duplication, and enhance effectiveness and efficiency across the current services and projects.

4.5.6 We would want the team to be able to access a single care plan with relevant information about the person so that a person's care through the system is co-ordinated be that in the community, in hospital, GP out of hours or ambulance services. We would envisage that the team would know the specialist team practitioners and be able to access clear referral systems that are linked to the specialist team with the shared care plan providing consistency.

4.5.7 There will need to be an understanding of skills and knowledge between the generic and specialist teams to ensure continuity of care across the interface.

4.5.8 The changing role of GPs and the primary care commissioning strategy would be central to the generic team design.

4.6 Specialist Teams

4.6.1 We believe that we have many specialist practitioners across our agencies that can provide services differently in a new delivery model. Indeed we have examples of change being driven in different areas in our system, such as the advice lines between consultants and GPs and specialist teams working with practice integrated care teams.

4.6.2 In developing the model we think we need to look at our current projects and services and make them into a more coordinated and tailored response to the new delivery model. In particular this will mean assessing those projects that are within the Central Integrated Care Board and the Central Manchester demonstrator model, ensuring that we are designing a model which learns from what we are doing and builds on the foundations of what we have.

4.6.3 However we think that we need to start looking at how we make a larger scale shift in this area. We need to see these services as predominantly being delivered in a community setting and, when needed, following the person into an acute setting to work with colleagues to enable the person to return home a quickly a possible.

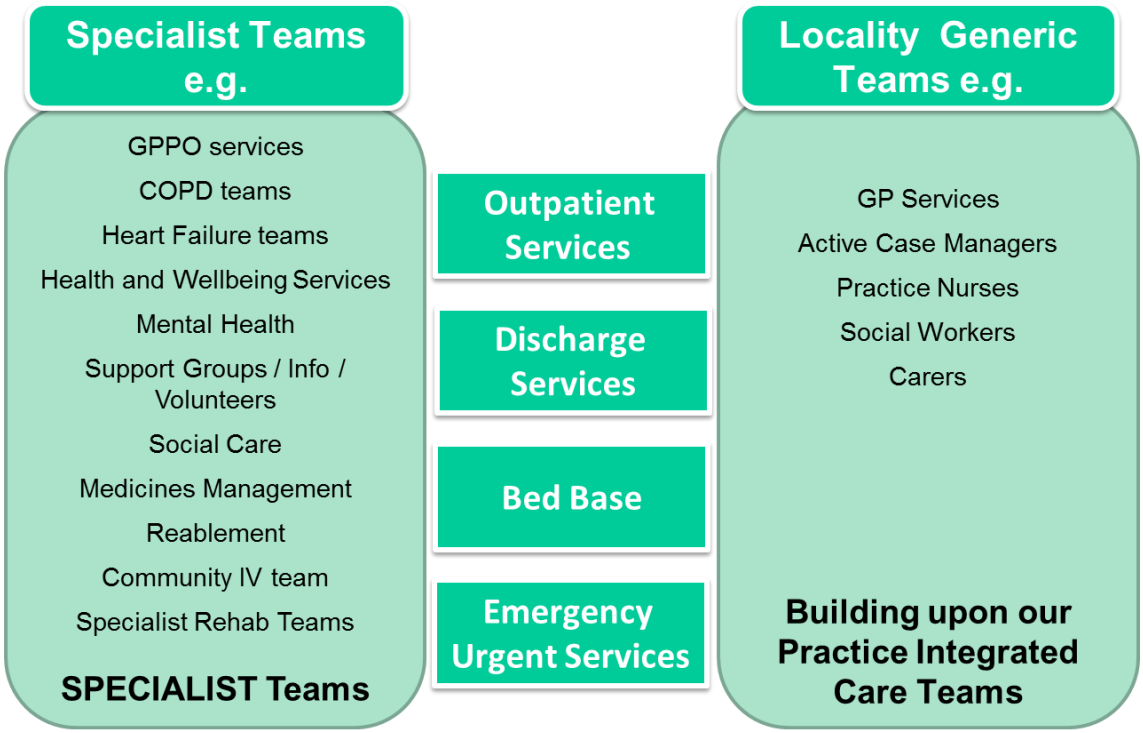
4.6.4 In doing so we would look at the place of delivery, how teams can deliver services in the locality, the referral pathways that are being used to ensure they are responsive and appropriate, looking at whether the access to specialist advice can be delivered in different ways. We would want to breakdown the silos between specialities and for those people with more than one LTC having a more joined up approach to specialist care.

4.6.5 We would also want the specialist teams, with patients and carers, to be part of the education on how to manage conditions. We see this not only as understanding how to live with a LTC but also how to manage one's own care plan. We would want to look at the role of the outpatient appointment within our new delivery model and whether it can be redesigned to a more responsive approach to an individual managing their own needs, accessing the outpatient facility when they need it, rather than when scheduled. We would look to build on the positive experience of the rheumatology service in changing their outpatient service to one based on need rather than schedule, where access is around symptoms rather than disease.

4.6.6 In a new delivery model we would envisage that specialist teams would need to operate under one framework so as to avoid duplication, and increase effectiveness and efficiency across the current services and projects. By understanding and predicting the number of people at a locality level, who would need or be engaged with the services, we could start to work with other organisations to have a more tailored and co ordinate response across urgent and planned care.

4.6.7 The diagram below outlines in pictorial form examples of who could be in our generic and specialist teams.

Diagram 5: Examples of who could be included within the generic and specialist teams



4.7 Carer support

4.7.1 We believe that as a system we currently do not recognise the amount of care that is being provided by carers across our city and the impact on the system if carers where not able to care. We also believe that as a system we have little understanding of the needs of the younger carers in our community and the affect that caring has, not only on their well being but their opportunities and potential. We want our new delivery models to start to address these issues through coproduction and involving and caring for carers more proactively.

4.7.2 We would want services to come together to provide carers with information and support to improve and maintain levels of mental and physical wellbeing and where appropriate referred to existing lifestyle services. We want carers to remain healthy and active.

4.7.3 To do this we need to be able to know the carer, identify their needs separate to the patient and be able to plan for their own care and well being. We would want the services to be able to offer this support through identifying the carer and their health and social care needs, enabling the carer to be heard, understood and involved, providing practical support such as information, respite care, patient advocacy, consideration of dependent children, housing.

4.8 April 2014 Onwards

4.8.1 The actions listed below are a summary of what we believe we could start to work on from April 14. It is dependent on there being agreement to the initial new delivery model, and the issue of transitional resources being addressed. Therefore, this is a high level view, taken from more detailed work we have undertaken, which would need to be further developed if the design was accepted.

- **Coproduction**

4.8.2 Establish a framework for co-production and design of the new delivery model between 2014-2020 by patients, carers, the community and practitioners. Explore this being shared with other new delivery models in Central and possibly across the city.

- **Coordination Centre**

4.8.3 Design for a co ordination centre across all the cohorts in EoL, LTC and frail older people to be drawn up to enable a simple number and response for patients, carers and practitioners to co ordinate a person's care around the system. Explore whether this can be shared wider than central if needed.

4.8.4 The co-ordination centre to facilitate information on and access to all agencies both statutory and non-statutory. Plan for access to information for service providers, patients, families and carers.

4.8.5 Co-ordinators in centre to develop access pathways to all services to facilitate ease of navigation through services and to monitor gaps in provision.

4.8.6 Improved more efficient way of micro commissioning packages of care and access to equipment, diagnostics etc to avoid duplication of effort.

- **Generic team**

4.8.7 Start to design the generic team building on the practice integrated team approach.

4.8.8 Identify both patients and their carers by name, location, GP Practice and condition/s, practice registers updated, accurate and shared, stratification of patient lists and prioritisation over agreed time scale.

4.8.9 Optimise services for the known patient group, with a consideration to develop community out patients clinics in localities with optimal numbers of people.

4.8.10 Review existing recording procedures and documentation across organisations to enable a consistent approach.

4.8.11 Design a shared core care plan used by all services both generic and specialist, this will include a self-care plan for patients, families and carers to use, an urgent care plan to share across services, patients and families to plan for appropriate response at times of urgent care needs

4.8.12 Develop and deliver services over 7 days and or 24 hours where appropriate. Services should be delivered closer to home by providing drop in and planned outpatient clinics in locality bases using generic team for input where appropriate. Appointments are tailored to patient needs.

- **Specialist Team**

4.8.13 Ensure the appropriateness and sustainability of the adult community services 5 year plan to this model.

4.8.14 Ensure the integration of projects in the GPPO and CICB portfolio are not duplicated but effective, efficient and appropriate to the model.

4.8.15 Test and evaluate specialist services increased presence in the community.

- Identification of patient's heart failure and appropriate specialist optimization of treatment through the integrated heart failure project.
- The COPD team to run a joint clinic with the Breathe Easy support group in Gorton. Explore locating this in the Market or in the library where Breathe Easy already has a presence.
- Explore the development of this clinic to include smoking cessation services, other public health and specialist services and the possibility of medical support. The clinic will be open access (no referral required) and will not be disease specific but symptom specific to relate to patients more. i.e. a breathlessness clinic.
- COPD integrated pathway with GPs to continue across the whole of Central Manchester.
- Development of the ICAT team to review all referred patients within 2 hours between 8am – 8pm

Section 5: Programme Leadership

5.1.1 This new delivery model design is a very ambitious programme of work to bring together numerous organisations and co produce a new delivery model over the next 7 years that will start to be implemented from April 14. Therefore, there will need to

be a governance structure that has within it a programme board and subsequent teams with skills that can deliver the change, not only in the service redesign, but the supporting infrastructure.

5.2 Estates

5.2.1 We will need to look at the beds available within Central Manchester for step up and step down care for people with long term conditions – this will mean assessing the need for support to people in the own homes, care homes and whether we will need to other beds in the community.

5.2.2 The Central Manchester area has three major parallel road systems to consider, Princess Parkway, Oxford Road and Stockport Road. This is important in terms of access for both staff and patients. Congestion is an issue and travelling time can affect efficiency and cost.

5.2.3 The growth of the population in the city centre has increased over recent years with a generally young population without many health resources. The city centre is historically part of North CCG but many of the urgent admission and ambulance activity that arrives at CMFT originates in the city centre.

5.2.4 The new GP provider organisation in Central Manchester is divided into four localities although it is unclear what their estates strategy is.

5.2.5 Whilst co location of different services does not in itself lead to integration it is a major factor in facilitating new ways of working. Integration should be based on the care model addressing the patient need and should not be just across professional boundaries but across organisations.

5.2.6 A hub and spoke model across organisations, as we progress new delivery model designs, would be a consideration for the estates domain.

5.2.7 We will also need to establish whether it is feasible to bring people together in terms being co-located across the city – space, facilities, parking.

5.3 Workforce

5.3.1 If we are to undertake this new delivery model design there is a considerable workforce component across all agencies and carers in terms of:

- Bringing teams together – virtually and to co locate
- Redesign of teams – roles and skill
- Joint training to change culture and raise standards and awareness

5.4 Information

5.4.1 The issue of information both in terms of being able to access information and using information technology to delivery care will be a crucial if the new delivery model is implemented. We would need to

- Access to records across the interface
- Mobile working to enable the delivery of care in people homes
- The production of technology to enable carers ad patients to remain in their own homes and in some cases deliver their own care

5.5 Finance and contracts

5.5.1 The cost benefit analysis has been addressed earlier in the document. However there is a considerable amount of work to be undertaken to ensure that the providers working together in a pre alliance contract. The providers will need to be able to trust each other and behave in a manner that will achieve the outcomes needed for the new delivery model.

5.6 Evaluation and Metrics

5.6.1 The Living Longer Living Better programme of work has high level goals which are:

- Add years and quality to life (choice of measures in next column)
- Help people to live more independently
- Improve health and social care outcomes in early years (0-4 years) in order to improve school readiness
- Reduce cost & volume of care in hospital
- Increase spend and volume of out of hospital services
- Improve experience of patients/carers at end of life
- Improve patient/carer experience of secondary care (inpatient and A&E)
- Improve patient/carer experience of primary care (general practice, dental services, out of hours)
- Improve patient/carer experience of community health services
- Improve patient/carer experience of social care / support services
- Improve satisfaction of workforce with new delivery models.

5.6.2 By designing a new delivery model we believe that we will contribute to these goals.

5.6.3 We understand that we will need to be held to account and measured on what the new delivery model aims to achieve. When developing our measures we will want to be clear on:

- Why the indicator is important in the context of the new delivery model e.g. clinically or financially.
- How we would expect the NDM to have an impact on this measure.
- What impact would you expect the NDM to have on this measure and on the corresponding balancing measures.

5.6.4 In order to measure how the new delivery model will work the following metrics have been identified for:

- Each service within the NDM
- The NDM overall
- The medium risk and high risk cohort

5.6.5 The commissioners will need to specify the number of people that we are aiming to see changes for. The Long Term Conditions NDM will then have specific shift measures in both activity and resource for the following metrics:

5.6.6 Reduction in:

- A&E attendance
- Admission to wards
- Out patients appointments
- Lengths of stay (e.g. Short stays / Bed days)
- Readmissions to hospital
- Admissions to residential homes
- Admissions to nursing homes
- NWAS transfers

These will be balanced by:

5.6.7 An increase in:

- Reablement services
- Identification of people in the cohort by primary care practitioner
- Activity in services in community settings
- People in the identified group who have a key workers
- People in the identified group who have a care plan
- Carers in the identified group who are known and involved in the care plan

5.6.8 We would want to develop with patients, carers and practitioners experience metrics that they consider important. We would also want to build on work that has been undertaken in previous integrated projects. Areas that we think would be important are:

- There is a well trained and confident workforce in Central Manchester
- Effective partnership working to deliver excellent care that meets the patient / carer needs.
- Patients and carers will matter and feel like they matter.
- Emotional and practical support is available.
- Care is co-ordinated across organisational boundaries.
- The service will be available to all on the basis of need not diagnosis.

Section 6: Conclusion

6.1.1 The document is an initial high level design for a new delivery model for long term conditions in Central Manchester. It has considered the emerging commissioner

care model and started the design process around 5 specific new delivery model components across a range of providers.

6.1.2 If the initial design was accepted there are still significant issues that will need to be worked through including the financial and contractual envelopes and the detail of how the model would be implemented and over what time scale.

6.1.3 Our understanding is that there is a considerable amount of work to be undertaken between now and the end of March with specific decision making points being:

- 20th December – Central Provider Partnership Board discussion as to whether to agree the initial design. If approved:
- 20th December design to be sent to the City Wide Living Longer Living Better team for inclusion in a January HWB Executive paper
- 8th January HWB Executive meets to discuss the programme
- 22nd January CICB meets to discuss and is asked to approve the initial new delivery model designs
- February and March HWB Executive, CPPB, CICB and HWB meetings to progress the programme of work.

6.2 Recommendations

6.2.1 The Board is asked to:

1. Accept the paper and it being sent to the city wide team
2. Acknowledge the time line and the progression of the paper
3. Acknowledge the work that needs to be undertaken if the new delivery models are to progress and actions needed between now and the end of March

Living Longer Living Better – New Delivery Model Design
Central Manchester

Appendix 1: Contributors to the NDM for Adults Long Term Conditions

		Workshop 1 11.11.2013	Meeting 1 25.11.2013	Meeting 2 4.12.2013	Workshop 2 12.12.2013
Angela Beacon	Project Manager, Central Manchester PICT	☑	☑	☑	
Beverley Hopcutt	Therapy Services Manager, CMFT	☑	☑	☑	☑
Carmel Breen	Manchester City Council				☑
Caroline Hourigan	Manchester City Council	☑	☑		
Chris Lamb	Adult Community & Specialist Services, CMFT	☑	☑	☑	
David Evans	Division of Medicine and Community Services, CMFT	☑			
Dawn Sewards	Go to Doc		☑		
Dianne Bell	Community Medicine's Management Team, CMFT	☑	☑	☑	☑
Emma Gilbey	Manchester City Council		☑		
Gary Foley	Adult Community & Specialist Services, CMFT	☑			☑
Gioia Morrison	Manchester City Council		☑		
Hetal Mainwaring	Manchester City Council				☑
Ivan Benett	Central CCG	☑			
Jane Barcoe	Assistant Chief Executive, Age Concern Manchester	☑	☑		☑
Jo Rothwell	Division of Specialist Medicine, CMFT	☑			
Julie Harrison	Active Case Management and Macmillan, CMFT	☑	☑		☑
Karen Kemp	Bowel Disease Nurse Practitioner, CMFT	☑			
Kate Tattersall	Adult Community and Specialist Services, CMFT	☑	☑	☑	☑
Kathy Hern	Adult Community and Specialist Services, CMFT	☑	☑		☑
Katrina Devall	Adult Community and Specialist Services, CMFT	☑			
Lucy Campbell	GP Gorton Medical Centre		☑		☑
Maeve Boyle	Manchester Mental Health and Social Care Trust			☑	
Paul Teal	Reablement, Manchester City Council			☑	
Sara Fletcher	Central CCG	☑		☑	☑
Sara Radcliffe	Programme Director for Integrating Care, CMFT	☑	☑	☑	☑
Shane O'Reilly	Respiratory Medicine, CMFT	☑	☑	☑	☑
Shawnna Gleeson	Manchester City Council				
Sonia Andrade	Public Health Manchester			☑	☑
Sue Lunt	Division of Specialist Medicine, CMFT	☑			
Susie Bowell	Ascertainment, Early Diagnosis and Optimisation LTC	☑	☑	☑	☑
Tina Davies	Consultant, CMFT	☑			
Vish Mehra	Chair, Central Manchester GPPO	☑			

Living Longer Living Better – New Delivery Model Design
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Appendix 2: Adult and Specialist Community Services 5 Year Plan

		Year 1	Year 2	Year 3	Year 4	Year 5	5 year vision
	Development of Practice Integrated Care Teams						Patients who do not require inpatient care will receive the care they need outside hospital: • Inpatients will leave hospital fully informed with ongoing care plans once acute care has been completed. • Integrated teams will deliver pathways of care for chronic disease management. • We will offer a full range of high quality end of life care supporting individual choice. • There will be an urgent 2 hour community response to health and social care need 24 hours a day.
Transactional Redesign	Initial pilots using existing resources	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	Savings invested in clinical staff and infrastructure	
Development of Integrated Care for Central Manchester at practice, locality and specialist level	Discharge Planning and Co-ordination	CHC coordination service	Upscale to cover CHC fast track assessments	Upscale to cover all discharges. Patients will be fully aware of their condition with self care options	All patients will have ongoing plan of care shared with integrated teams prior to discharge.	All patients will be ready for discharge when acute care is complete and arrangements in place to accept their ongoing care.	
	Long Term Conditions	Community Care pathway for COPD	Roll out COPD pilot to all CM & pilot next chronic disease pathway i.e. heart failure	Upscale 'heart failure' pilot to all CM & pilot integrated pathway for 3rd chronic disease i.e. diabetes.	Upscale diabetes pilot to all CM localities & pilot integrated pathway for frail elderly.	All patients with for example COPD, heart failure, diabetes and the frail elderly will be managed by integrated teams at home	
	End of Life Care	End of Life care in residential Homes	Design a multidisciplinary robust hospice at home model.	Implement and deliver a multidisciplinary robust hospice at home model	Commission end of life beds outside hospital co located with intermediate care	All patients on end of life pathways have a choice of location for receiving high quality end of life care outside hospital & preferred place of death is met.	
	Community Health & Social Care Urgent response (ICAT)	Community response to falls	Include new pathways i.e. diabetic hypos, frail elderly, urinary catheters	Upscale to two hour response in partnership with city council.	Expand service to cover 24 hours response	An urgent 2 hour health and social care response for all appropriate conditions including NWAS self care pathways.	
Quality Patient safety Efficiency	Workforce development, Education, Skill mix, Care pathways, Shared care, Redesigned teams						

Central Manchester NDM Version 6 / SR LTC CPPB meeting 20th December 2013

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Appendix 3: Supporting Information

The following supporting information is available at request from Katrina Devall. If you would like a copy of any of the documents below, please email katrina.devall@cmft.nhs.uk.

1. **Health and Wellbeing Board reports:**

Living Longer Living Better Blue Print, March 2013
Living Longer Living Better Strategic Outline Case (Part A and B), July 2013
Living Longer Living Better Business Case, November 2013

2. **Commissioner Care Models:**

Adults with Long Term Conditions
End of Life for Adults and Children
Frail Older People and Adults with Dementia

3. **Central Manchester New Delivery Models:**

New Delivery Model for End of Life Care
New Delivery Model for Frail Older People and Adults with Dementia

4. **Bibliography for the Long Term Conditions Model**

New Delivery Model for South Manchester Frail Older People and Adults with Dementia

1. Introduction

The paper describes the new delivery model for older adults with frailty and adults with dementia which has been produced by a number of providers working together in South Manchester – appendix 1.

This work has been undertaken in response to the Living Longer, Living Better programme, and the care model components and standards produced by commissioners. In South Manchester, our Neighbourhood Teams are the bedrock with which we will build our new service delivery model upon.

The model will evolve over time and this is the start of a process by which we can work together to achieve effective ways of delivering timely care which is determined by a person's needs, and reflective of their current situation. Our triple aim is therefore to deliver care for our target population which:

- Centres on the needs of service users
- Makes best use of available resources
- Can be sustained in the long term

To achieve these ambitious aims we must rapidly move to a position of mutual understanding of the following:

1. The scale and range of demand (some of which may presently be unrecognised) within the chosen target population
2. The scale of resource which must be deployed to meet these demands going forwards
3. The outcomes we expect to deliver and how they will be described
4. The best available delivery models deliver our outcomes, mindful that some may not yet have a robust evidence base and that new untested models may require development
5. The performance indicators which will enable us to ensure our care models are effective and best values for money

We recognise that there are a number of key infrastructure areas which are critical to successful delivery and which will require considerable work:

- Workforce, contracting and HR mindful of the drive for 24/7 delivery
- Estates
- Information technology
- Data governance
- Procurement, specification and contracting of services

We also recognise the need to work within local, conurbation-wide and national frameworks with respect to:

- Quality assurance
- Quality improvement

We acknowledge that this is a high level, strategic description of our new service delivery model, and further detailed descriptions and timescales are required in order for this to start to feel real to our staff and patients.

2. Background

2.1 The Design Group

The design group consisted of almost 70 people from a wide variety of providers across South Manchester including voluntary groups such as Red Cross and Age Concern. The strong engagement and involvement of voluntary sector colleagues in the design of a new delivery model, makes this both a unique and radical vision of care. We also understand the need for good clinical engagement to gather support for these changes and clinicians were majority stakeholders at both the workshops and delivery group meetings .Clinicians came from a wide variety of organisations including UHSM, GP providers, Out of hours and NWAS. The names of the attendees and their organisations are attached in Appendix 1.

The new delivery model was co –produced by the design group at 2 workshops led by colleagues from AQuA which mapped current pathways of care to identify waste and duplication, before mapping key areas of work onto an ideal state .The workshops were well attended with good engagement in the co –production process reflecting delegate's commitment to a new model of care. The initial plan was to develop 2 separate models of care for End of Life Care for Older People, Frail Older People and Adults with Dementia but mapping pathways convinced us that what was needed was one new delivery model which would identify the relevant components of care at each stage. Even though the detail and aspects of demand and delivery may differ between individual service users the key elements of care for a person are the same irrespective of the underlying clinical conditions. A single delivery model to address the needs of the population in focus has therefore been developed.

A smaller working group has met several times since to further refine the new model .The representatives of this smaller group is attached in Appendix 2.

2.2 The Commissioner care model.

Commissioners have led a series of workshops over the summer defining the care model components for the 5 priority population groups as agreed by the Health and Well Being Board, listed below:-

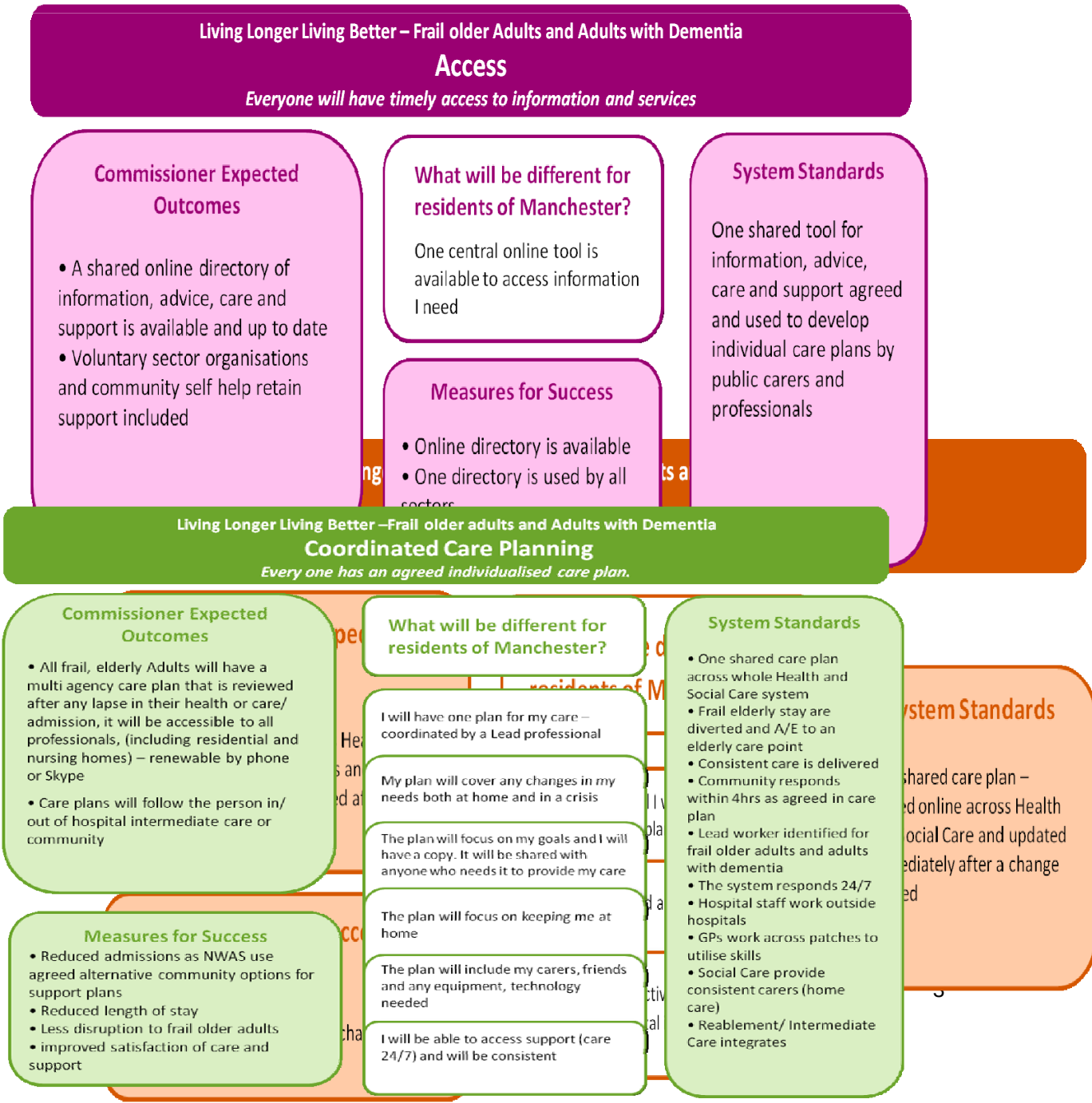
- Adults with Long Term Conditions

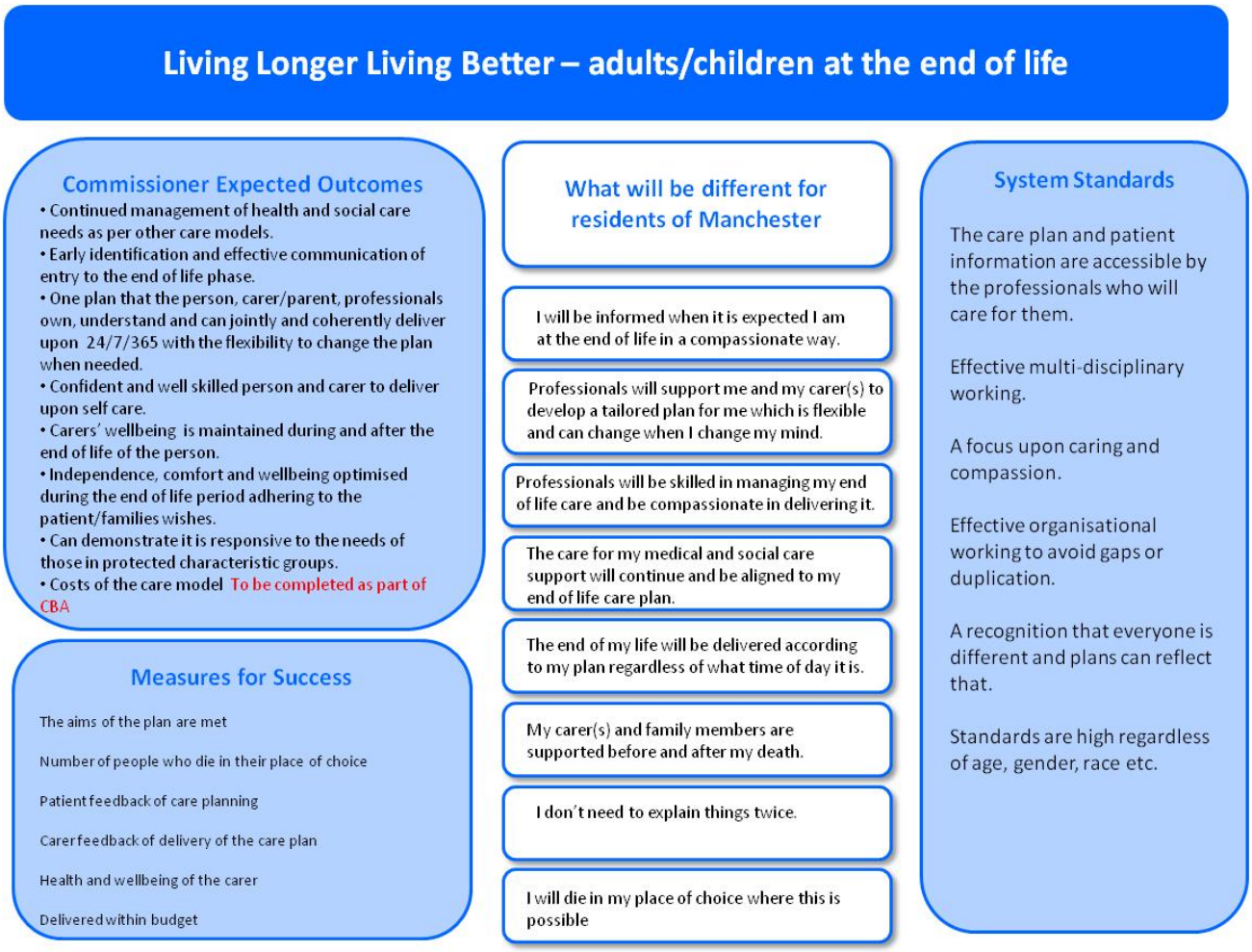
- Adults with Complex Needs.
- Children with Long Term Conditions
- Frail Older Adults and Adults with Dementia
- Care at End of Life

These priority care models are those where the commissioners anticipate the greatest level of shift can be achieved in terms of moving spend and activity from hospital to community services.

They have also been developed as the population group that has been identified as most likely to benefit from an integrated model of care. Commissioners continue to work on the detail of outcomes required from the new delivery models.

The components of the care models are set out in the diagrams below.





The South Manchester provider design groups initial work has built on work commissioners have undertaken to describe the components of care they wish to commission for Frail Older Adults and Adults with Dementia. Initially we had determined that this population group would be our focus, however as a result of the first workshop, it became apparent that it is not possible to develop a new service delivery model for frail older people and people with dementia without addressing their palliative care and end of life care needs aswell. As a result this new service delivery model has started to build the model for end of life, although it is acknowledged that further work will be required to develop an end of life model.

2.3 Local work

2.4

There are many different examples of other local work that are congruent with and offer important learning for the design, development and implementation of this new care delivery model for South Manchester's frail older people and people with dementia as well as care for those people who are in the last year of their live.

ASPIRE – this pilot scheme offers people with a respiratory condition alternative and safe care outside of the hospital. The pilot includes both a step down service from hospital, and a step up service from primary care for people who choose to receive their high quality, effective and safe care closer to home. People who are stepped up from primary care are identified via our integrated neighbourhood teams and those people who are stepped down from the hospital are identified by a respiratory consultant and join ASPIRE's virtual ward; incorporating a person's home or a health centre.

Stroke Early Supported Discharge – this pilot has two strands of care, with a third strand under development. The first offers stroke patients with moderate disability, early supported discharge to their family home once medically stable, by providing specialist assessment, individual rehabilitation programme and social care support by a consultant led multidisciplinary team to achieve the patient's, and their family goals in the community and comparable to the care received in an in-patient stroke unit.

For those patients who have previously had a stroke, and who remain under the care of their own GP and are experiencing increasing difficulties in their ability to manage activities of daily living, as a consequence of a stroke related problem, receive prompt intervention and specialist stroke therapy team in the community.

Consultant led multidisciplinary approach, specialist assessment and individual rehabilitation programme to meet the person's, and their family's goals, care coordination and carer support are key elements of this safe and alternative offer to hospital care.

Neighbourhood Teams - In south Manchester we have implemented our integrated neighbourhood teams who provide assessment and care to people with long term conditions outside of the hospital. Our delivery model is organised around General Practice and uses a multidisciplinary approach e.g. GP, community nurse, mental health and social worker. Care planning and coordination are key elements of this safe and alternative offer to admission. Patients are selected for the service using a combined risk stratification tool. Our use of this risk tool enables the targeting of 20 percent of the GP population; ranging from those who are a very high to moderate risk of hospital admission and includes people who are frail older people and people with dementia. Our Neighbourhood teams are starting to demonstrate a positive impact upon patient care and our new service delivery model will be built upon the successful integrated working of the teams.

Integrated Discharge Team - For the first time, social workers for Manchester and Trafford, the Hospital Discharge Team and the Community Nurse Assessors are integrated; managerially, clinically and are co- located as one team. This has enabled the team to work together more effectively, to share patient information and understand each others' roles and responsibilities in order to achieve a more streamlined discharge process and improve the experience and of the discharge process for patients and their families.

Community Diabetes Service -The Community Diabetes Service was designed to enable people with type 2 diabetes who have problems of intermediate complexity

and would otherwise be referred to secondary care, to receive their care quickly and outside of the hospital from a health and social care multi-disciplinary led by diabetes experts. This pilot created the valuable opportunity to test the community consultant role.

People with diabetes were supported with education to support autonomy and confidence to self-manage and reduce the need for clinical intervention. Whilst professional education was provided by diabetes experts to increase the level of diabetes expertise in primary care and thereby address the variation in diabetes care within primary care to ensure minimum standards of care are consistent.

PADS – The hospital Proactive Discharge Scheme uses a validated frailty phenotype screening tool on day 3 of all admission to predict those patients aged +75 most at risk of delayed discharge from hospital. The scheme real time maps these patients by ward area and links together other key data points including s2/s5 status and dementia diagnosis. At a glance it enables the Trust to determine its global occupancy and frailty occupancy by ward to target proactive discharge planning interventions via the integrated discharge team and promote flow into other systems (such as rehabilitation, intermediate care) for those likely to benefit. A no-move rule (excepting clinical necessity) ensures reduction in excess bed-day demand through internal movement with identified benefits of maintained care continuity and reduced diagnostic duplication.

Community Nursing – Assuring that our community services are equipped to offer safe and high quality care closer to home for those people with increasing levels of complexity and in collaboration with our provider partners is vital. Our new community nursing service brings the expertise of district nursing and active case management together to provide this offer. Our community nursing service is the outcome of a comprehensive review that engaged staff and stakeholders in the design of the future care model. Organised around primary care patches with a referral coordination point for all community nursing referrals, including step up from community and step down from hospital, and all other referrals, this new model aligns the expertise and experience of our nursing staff with the increasing complexities of need to offer safe out of hospital care for people.
Palliative Care – In line with our development of a community nursing service for south Manchester, and following the transfer of community palliative care service to UHSM as provider organisations in 2011, we have now embarked on a comprehensive review of UHSM'S palliative care, specifically the discrete acute and community functions that currently exist, and concluding in early 2014. Again our approach here has been to engage with staff and stakeholders in the design of a future care model for south Manchester offer a more patient-centred and co-ordinated support from the point of diagnosis all the way through treatment and beyond. In doing so we have harnessed the shared expertise in this field, incorporating the outcomes of key strategic developments taking place in palliative care, such as the Macmillan Manchester project **"**Redesigning the System".

Whilst the examples of local work described above do create a platform from which to build upon, the pilot schemes are short term in nature and the other examples are in the early stages of the change management process.

Supporting and expanding areas of promising practices will require early investment in the underpinning infrastructure that is vital to embed these new and innovative approaches to achieve lasting change.

2.5 Need for Change

As part of the commissioners process in working up priority care model groupings, they have identified 'big ticket items' .These are priority items which will have the most impact and make a difference to the lives of Manchester people and will also be able to shift resources were they are most needed .That means a shift to out of hospital services at a scale and pace that will be effective and efficient for patients in the future, improve outcomes and deliver the aims of LLLB.
The big ticket items for Frail Older People and Adults with Dementia are

- Delivery of safe care at home
- One care plan
- Early identification of people with dementia
- Frailty assessment tool

The big ticket item for Care at End of Life

- Hospice model of care
- Integrated information and delivery of services.

The Manchester Health and Well Being Board have approved a blueprint for the Living Longer, Living Better programme which sets out the ambition to build out of hospital services and to shift care from acute hospitals .The overall aim is to deliver excellent community based co-ordinated care for Manchester people.
Delegates at the South Manchester workshop stated that they believed there was a need for clarifying pathways, a need for proactive services with early intervention and a community focus.

They stated that we should build on what we have, deal with inequalities and have better co-ordination, reducing duplication and working better together with a focus on caring.

2.5 Frail Older People and Adults with Dementia

People aged 65 and over make up 16 per cent of the population nationally and occupy almost two-thirds of general and acute hospital beds accounting for one-half of the recent growth in emergency admissions. Population ageing is projected to continue, with the number of people in the UK aged 65 and over increasing by nearly two-thirds to reach 15.8 million by 2031. The greatest population increases are projected for the oldest of the older age groups. By 2031 a 77% increase is expected in the number of those aged 75 and over with a 131% increase in those aged 85 and over.
South Manchester in particular has an issue with increasing numbers of admissions of frail elderly and people with dementia. Using the commissioners LLLB Care Model definition of frail elderly and people with dementia; over 6000 admissions were made to the acute hospital, for the period: 2012 and 2013. 18% of A&E attendances at South Manchester are people over 70 years which is significantly higher than the North West average.
At the workshop phase of the co-production the issues of multiple assessment and lack of co-ordination was overwhelming.

2.6 End of Life Care

National studies have consistently indicated that around 70% of people would prefer to die at home yet only 20% do so (Dying Matters Coalition, 2012). In the North West in 2010 64% of patients expressed a preference to die at home and hospital was their least preferred place of death (Gomes & Higginson, 2010)). The National End of Life Care Intelligence Network showed that in 2005-2007 most people in England died in hospital and according to the National Audit Office (201140% people dying in hospital have no medical need to be there and 59% of people state they are frightened of dying in hospital.

The numbers for South Manchester are highlighted below:-

CCG Code	CCG Name	Place of Death	Total deaths 2010-12	Average annual deaths 2010-12	Percent of all deaths
01N	NHS SOUTH MANCHESTER CCG	Care home (nursing or residential)	459	153	12
01N	NHS SOUTH MANCHESTER CCG	Home	869	290	22.8
01N	NHS SOUTH MANCHESTER CCG	Hospice	156	52	4.1
01N	NHS SOUTH MANCHESTER CCG	Hospital (acute or community, not psychiatric)	2236	745	58.7
01N	NHS SOUTH MANCHESTER CCG	Other Places	92	31	2.4
		Total	3812	1271	100.0

2.7 Proposed Shift

Our new model care will deliver significant shift in the location of service activity and resource from the hospital site to alternative, credible and safe care provision that will be available in many closer to home locations. Our shift of services will be demonstrable and must be sustainable.

Commissioners have provided their initial objectives and targets for frail elderly and adults with dementia and care at the end of life new model of care for across the city, see appendix 4. As these targets are for the City of Manchester as a whole, their further refinement to reflect South Manchester's context and baseline will be important. Refining these targets will underpin our measurement across the South Manchester system of the scale and pace of shift over the next 5 years.

At this stage, we envisage this shift in activity and resource to bring many demonstrable benefits including:

- Our voluntary sector partners playing an increasing role in service provision of service, both in terms of activity and value

- Credible and safe care alternatives to existing provision available outside of hospital offering high quality care and available over extended hours
- Patients and carers receive their care in accordance with their care plan and with an increasing numbers of people dying in a place of choice
- Increased number of elderly people assessed and registered as frail in community setting, with the corresponding reduction in unscheduled admissions and length of stay for adults who are older than 65 years
- Our workforce is empowered by shared electronic patient information accessible in multiple care settings
- Patients and carers who are empowered to self manage and care

In early 2014, our design groups will undertake analysis to define and quantify shift across South Manchester's system; by individual service and year. This plan will also include any dependencies such as enabling measures or pump priming resources that will need to be in place in order to establish credible and safe out of hospital care alternatives.

3. Current Service Profile

In South Manchester our current offer is characterised by high and increasing levels of hospital admissions of frail elderly and with dementia adults and by more people dying in hospital than both the national and regional averages.

There is no hospice located within South Manchester, or a "hospice at home" model of care commissioned and available to south Manchester residents. However, St Ann's Hospice is situated in Heald Green, Stockport and does offer inpatient care.

Many services operate in South Manchester to provide high quality care for frail elderly and with dementia adults and for those who are at the end of life, these include specialists in geriatrics and palliative care, social and community care teams, general practice, charitable organisations all of whom work across organisational boundaries and in multiple settings. This demonstrates the wide range of services available and also highlights the risks that are associated when coordination is service based and reliant upon informal networks and communication, of the potential for unintended duplication, fragmentation of service provision and breakdown in communication that can result in inadequate care.

This may help to explain the view of patients and carers reported at a recently held Manchester LLLB patient and carer engagement event, patients and carers were asked about the existing services for frail elderly and with dementia adults and end of life. 32 per cent of respondents considered the existing services for frail and elderly and with dementia adults as poor, with a further 18 per cent considered these to be very poor. Whereas existing end of life care services were considered as average by 21 per cent and as poor by 19 percent by those patients and carers who attended the event.

In our design workshops service providers mapped the current pathway for Mrs Pankhurst during each of the stages of the frailty pyramid:

- Keeping Mrs Pankhurst well and at home
- Preventing admission to hospital when Mrs Pankhurst becomes unwell
- Getting Mrs Pankhurst out of hospital
- When Mrs Pankhurst needs palliative and end of life care

An example of how this exercise looked is shown below:-

3.1 Current Providers

In south Manchester there are multiple providers of services working across the locality that currently offer care for people who are frail elderly, with dementia and for people who are at the end of life. We have included those service provider partners at this design stage that will be core to our new delivery model - category A – and - category B – the services that will be impacted by services by the new delivery model.

Services Include

Category A – core services to NDM
Active Case Management - UHSM
A&E Department- UHSM
Integrated Hospital Discharge Team- UHSM
Ambulatory Care Unit/GP Assessment Unit - UHSM
Adult Social Care - MCC
North West Ambulance Service
ASPIRE Service - UHSM
COPD Service - UHSM
Day Hospital - UHSM
District Nursing – Days and Night Service- UHSM
Falls Service - UHSM
Funded Care - UHSM
General Practice
Geriatric Wards - UHSM
Intermediate Care Service - UHSM
Macmillian Palliative Acute and Community Care Service-UHSM
Macmillian Information Centre - UHSM
Adult Social Care - MCC
Manchester Equipment and Adaptation Service - MCC
Parkinson Disease Service - UHSM
Neighbourhood Teams – UHSM/MCC/MMHSCT
Residential and Nursing Care Services
Nursing Home Case Management Service - UHSM
Out of Hours Medical Services ‘Go to Doc’
Palliative and Supportive Care Services - UHSM
Primary Assessment Team - MCC social care agency providers
Reablement Service - MCC
Acute Therapist Services - UHSM

Continence Service- UHSM
Psychiatric Liaison Service -UHSM
Tissue Viability Service - UHSM
Community Specialist Services e.g. heart failure - UHSM
Early Supported Discharge Service - UHSM
Proactive Discharge Service - UHSM
Community Therapist Services - UHSM
Voluntary Sector Services

Category B – Impacted services by NDM
Hospital Heart Failure Service - UHSM
Stoke Ward and TIA Service - UHSM
Medicines Management Teams
Orthogeriatics -UHSM
Inpatient Rehabilitation Ward
Diabetes/Endocrinology - UHSM
Speciality Wards - UHSM
Interstitial Lung Disease Service - UHSM
Long Term Ventilation Service- UHSM
General Infectious Diseases - UHSM
Medical Specialities e.g. clinical haematology & anticoagulation - UHSM
Rheumatology Service -UHSM
Dermatology Service -UHSM
Diagnostic Services -UHSM
Neurophysiology-UHSM
Renal Service-UHSM
Outpatient Services- UHSM
Cystic Fibrosis Service- UHSM
General Nursing & Medical Services -UHSM
General Medical Outpatient Services -UHSM
Neighbouring Trusts
Urgent Care Centre
Acute Medical Unit- UHSM
Alcohol Liaison Service - UHSM
Community pharmacies
Clinical Decision Unit - UHSM

3.2 The current gaps

When examining the current pathways of care and of provision by location, our analysis found a number of significant issues and current gaps in our service provision:

- Duplication of assessment being undertaken by health and social care professionals and in multiple care settings.
- A lack of end to end coordination of care for the patient throughout the whole of their care pathway which incorporates their diagnosis, treatment and care, with care coordination often handed over at the point of transfer into a different care setting or service and leading to fragmentation of care and service provision.

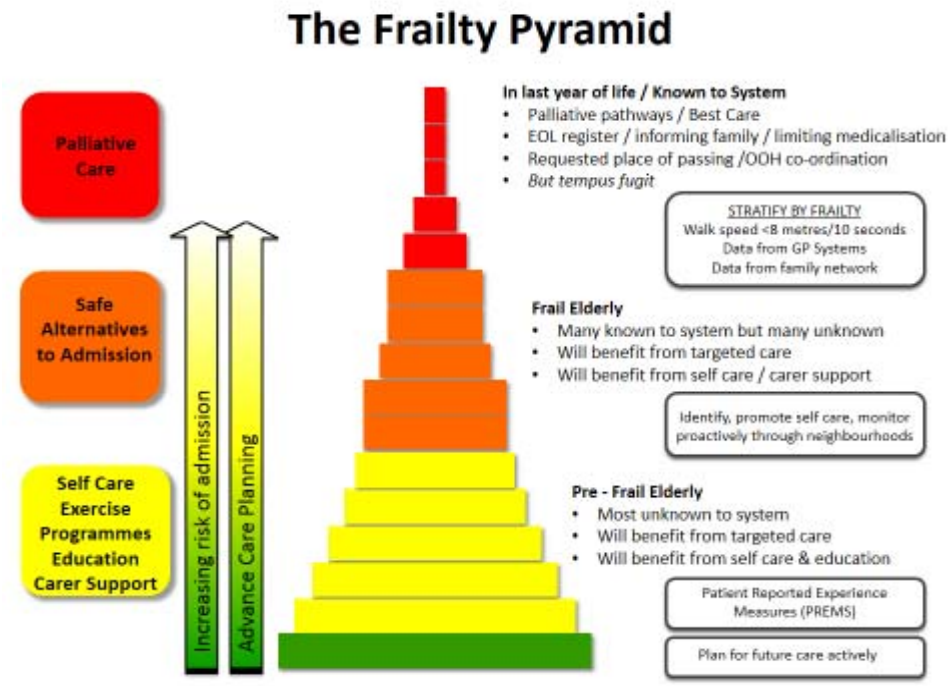
- Inadequate services and support for patients who are palliative and in need of high quality palliative care outside of normal business hours and in particular during the night. A lack of credible alternatives tends to reinforce a reliance on the emergency services.
- The geographical area covered by the North West Ambulance Service means that South Manchester will be served by ambulance crews from across the north west of England. Therefore the level of local knowledge held amongst crews is variable.
- Role of the community consultant providing specialist medical assessment is limited to geriatric and palliative specialities.
- No single access point for patients or carers to services.
- A longstanding inability to systematically share patient information or their care plan electronically with other relevant practitioners across organisations and services, however South Manchester's neighbourhood teams are piloting the use of the graphnet system for shared care planning.

4. New Delivery Model

We have used the frailty pyramid as developed by Dr M. Vernon as a guide when designing the new model of care.

Frailty is an expression of population ageing which can be easily identified, observed and quantified. Fried (Cardiovascular Vascular Health Study) and Rockwood (Canadian Study of Aging)

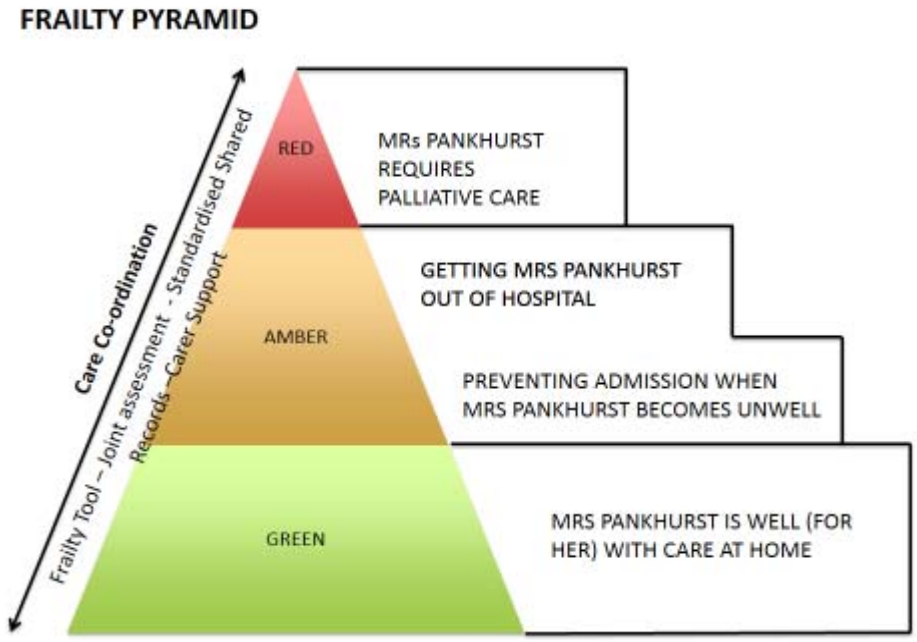
The frailty pyramid below was designed to show the different stages of frailty. Patients can be stratified by the use of a simple frailty scale which has been developed to be used by health and social care professionals, family and carers. Typically patients are on a 4 to 7 year journey as they move through the stages of the pyramid.



4. The Model

The model of care is focused around 4 areas and the outline of the model of care is below.

- Mrs Pankhurst is well (for her) with care at home
- Preventing admission when Mrs Pankhurst becomes unwell
- Getting Mrs Pankhurst out of hospital of hospital
- Palliative Care



The overarching statements that came through in both workshops was that South Manchester would want to deliver community based care that was person and carer centred with an anticipatory approach .The system would be integrated and proactive promoting self-care and active lifestyles. The main focus of work will be on prevention and enabling people to manage their own health at home and be independent of public sector service provision.

High quality specialist support would be delivered when necessary and in a timely manner.

The head line statements that came out of the workshops and development meetings which run through each stage of the pyramid were:-

4.1 Care Co-ordination

The care component that was highlighted most as a gap in the current system was co-ordination of care, which was felt by delegates, that if rectified could have the potential to reduce duplication and improve the quality and safety of the services that health and social care provide .Health and social care professionals at both workshops repeatedly flagged the issue of care workers not knowing what other services are providing. A key worker who could co-ordinate the care that the person receives would improve care and could have the potential to reduce costs.

4.2 Frailty Tool

The frailty tool is not used proactively in the current system and many delegates at the workshop were unaware of the potential of the tool to highlight the need for services in the future.

The 7 point Clinical Frailty Scale is based on a more complex 70 indicator Frailty Index (Canadian Study of Health and Aging) and the points are shown below.

1. **Very fit**: robust, active, energetic, most fit in age group
2. **Well**: without active disease
3. **Well with treated co-morbidity**: well controlled disease symptoms
4. **Apparently vulnerable**: not dependent but ‘slowed up’
5. **Mildly frail**: limited dependence on others for some ADL
6. **Moderately frail**: help required for all ADLs
7. **Severely frail**: completely dependent for ADL or terminally ill.

Used with the existing risk stratification system in South Manchester the tool will enable identification of frailty so that a plan of care can be immediately developed to try and support the older person to remain safe and fulfilled at home for as long as possible.

The design group had a long discussion about the naming of the frailty tool, with many members keen to change the name to a tool to well being or dependency as it was felt that nobody would choose to be referred to as ‘older’ or ‘frail’. This was felt to be difficult as this is a widely recognised name for the tool.

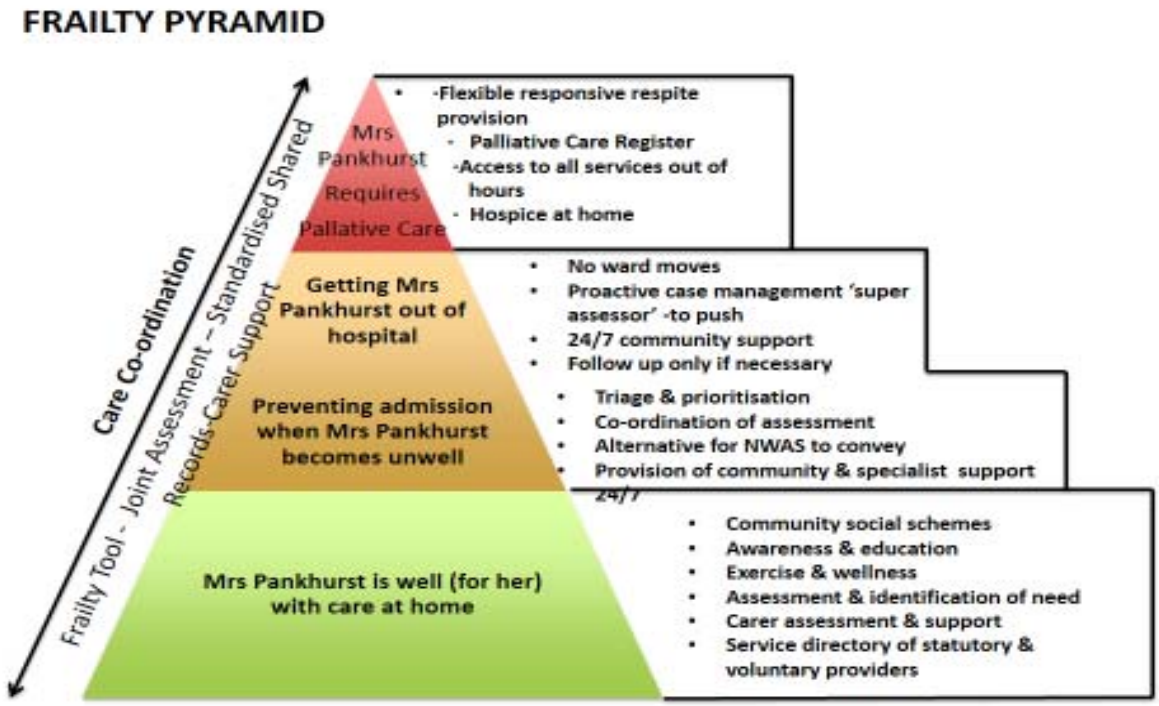
4.3 Joint Assessment and Standardised Shared Records

One of the most striking outputs was the repeated number of assessments that are required at each stage of a patient’s care, so the need for joint assessment, wherever practical and one single care record that can be accessed by all was felt to be a key component of the new model. The single care record should consist of a standardised front end to avoid repetition. All assessments currently contain a core set of information about the individual which if shared would massively reduce the duplication.

4.4 Carer support

Almost all delegates at both workshops recognised that a huge gap in the current services was carer support. Carer contribution is essential in supporting the new service delivery model to work, and carers will need to be more involved in the development of care provision in the future. The new delivery model will provide carer support as standard at every stage of the patient's pathway.

5. Components of Care



The detailed pyramid of care above sets out the components of care that would be required to be delivered at each stage of the pathway that has been co-produced by the provider delivery group. They cover each of the commissioner care components and big tickets items. Further details about how the new model of care will address the current gaps in the care system are described below.

5.1 Mrs Pankhurst is well (for her) at home.

Community social schemes

- Friendship schemes
- Social activities in centres and other community buildings
- Tea dances and outings
- Outings
- Engage older people as citizens in the urban environment

- Access to parks and leisure services

Awareness & Education

- Planned retirement courses
- IT training
- Facilitated self care
- Educate family about what care is available ,what to do if a patient is unwell and how to care for home
- Welfare rights and debt advice
- Healthy living advice

Exercise & wellness

- Exercise class
- Exercise plan
- Activity groups for people with dementia

Assessment, co-ordination & identification of need

- Advanced care plan that a patient owns and can articulate
- Active case management care co-ordination ,one contact proactive assessment
- MDT including frailty assessment and other non specialist assessments.

Specialist assessments that are co-ordinated (in order to avoid duplication and un-necessary assessments) including CPA, best interest meetings.

Provision of a service directory of statutory & voluntary providers

Summary

The components of care listed above would be delivered by a single point of access with a key worker who would co-ordinate care and referrals. The key worker would have access to all the social and health interventions that could enable Mrs Pankhurst to stay well at home. The key worker will be of any professional discipline, dependent on the needs of the person. Frailty assessments could be initiated by patients and carers supported by voluntary sector staff, as well as health professionals and would supplement primary care risk stratification. Further specialist assessments would only take place when necessary and would build on initial assessments. There would be a single care record which could be accessed by all. There would be an up to date web based service directory.

5.2 Preventing admission when Mrs Pankhurst becomes unwell

Triage and prioritisation

Single point of access to ensure Co-ordination of appropriate assessments at home ensuring no duplication

MDT assessment of need and development of care plan.

Co-ordination of Assessment

- Personalised care plan.
- Nursing home service key contact
- Ensure neighbourhood team key worker follows patient through journey

Alternatives for NWAS to convey

- NWAS referral to other agencies
- NWAS access to alternative services

Provision of Community Specialist support 24/7

- Reablement out of hours
- Equipment and home adaptations
- Respite care
- Intermediate care team at home
- Specialist falls and fracture liaison

Summary

Building on the initial care components key workers, patients and carers would have access to rapid assessment .This would be by the most appropriate health and social care person who would triage and prioritise care in a timely fashion via a single point of access.. The key at this stage in the new model of delivery is that interventions take place promptly and in the community if at all possible. Frailty assessments should take place if they have not already done so. The key worker should also co-ordinate intensive community provision and specialist outreach support. We know that some hospital admissions currently occur due to poor access to community based services so they must be available 24 /7.

5.3 Getting Mrs Pankhurst out of hospital

No ward moves

- As identified by PADs 2 project

Proactive case management 'super assessor ' pull not push

- Robust ED assessment including frailty with links to electronic patient record and links to community and key worker
- Specialist assessment, including old age psychiatry
- Advance care planning
- Risk assessment at home
- Integrated MDT assessment in admission ward
- Discharge plan on admission with early identification of support required
- Clear discharge summary and discussion with primary care.
- Any acute service able to refer to any primary care service.

24/7 community support

- Rapid access to care packages
- Rapid access to step up/down beds
- Rapid Access to senior doctor review
- Social prescription
- Access to timely equipment and adaptation if necessary
- Day hospital for exercise programme.

Hospital Follow up only when necessary

Summary

If Mrs Pankhurst is admitted to hospital the new delivery model will again build on the above two care components. As well as ensuring that she receives high quality services in hospital from a specialist team who will be co-located to deliver services that minimise the time that she spends in hospital, there should also be a pull from community services. The intensive community provision should be available 24/7 along with specialist outreach support plus a plan for ongoing support to reduce level of need including planning for the crisis situations.

5.4 Mrs Pankhurst requires palliative care

Flexible responsive respite provision

- Respite beds
- Respite provision at home

Hospice at home

- Macmillan Service training for all professionals
- Advanced care planning
- Care plan accessible to all including NWAS
- Specialist palliative care advice
- Supporting choice of place to death

Palliative Care Register

- Register available and used by all.

Access to all services out of hours

- Night sitters
- Community Nursing Services
- Social Care particular to support discharge.
- Residential Care

Summary

The need for a key worker who co-ordinates services , standardised share records, advanced care planning ,intensive community support that are the thread through all this model are equally important here. However the ability to access all relevant services out of hours was felt by the design group is currently a gap in services that the new delivery model would address.

5.5 What will be different as a result of this new service delivery model?

For Mrs Pankhurst?

At all stages of her care, Mrs Pankhurst will be engaged in and involved in her care plan and she will understand what she can do in order to stay well. She will have one care plan. She will be cared for by a team of staff who know her and she will only be assessed for her needs if her co-ordinator has decided that it is appropriate for her. If she needs anything to help her maintain her health and wellbeing she will know who to contact and the contact will be quick and easy for her; day or night. She will be able to continue to be as close to home as possible whatever stage of her care. If she requires hospital admission for specialist care, she will be supported

to be discharged as soon as possible by a co-ordinated team of staff working across the hospital and community.

For Mrs Pankhurst's carers and family?

Mrs Pankhurst's carers will be supported by our integrated teams so that they can maintain their own health and wellbeing. With Mrs Pankhurst's permission, they will be involved in Mrs Pankhurst's care planning and decision making about what she may need if any changes occur to her health and wellbeing or to that of her carer. They will know who to contact if anything does change and the response to them will be rapid and consistent.

For our staff?

It may not be as obvious to Mrs Pankhurst whether our staff are from health or social care as they will work more closely together in an integrated way, building upon our learning from our Neighbourhood Teams, and they will share one IT system. They will be supported to work in a much more fluid way across the acute trust and the community setting. Dependent upon Mrs Pankhurst's needs, one of the team will act as her co-ordinator who will reduce the number of assessments that she needs and ensure that the assessments that do take place are undertaken in a consistent and collaborated way. The staff will work with a single point of access to ensure that Mrs Pankhurst receives the most appropriate care, provided by the most appropriate staff and in the right place. More of the care provision and support will be undertaken by staff in the voluntary sector. All staff will focus upon the needs of Mrs Pankhurst and those of her carers.

6. Measurement of Success of the New Delivery Model

Work is currently underway across the city to agree the measurement and evaluation of the Living Longer, Living Better Programme. The set of measurable outcomes to demonstrate the effectiveness of the programme of time are contained within appendix 3. Due to the scale and complexity of the programme the citywide team is seeking to utilise the academic links that exist through the Manchester Academic Science Centre.

Further work is required by commissioner and provider partners locally to develop the Performance framework for south Manchester's new care delivery model in early 2014 in order to measure shift in both activity and resource (workforce or money) for the following metrics:

Reduction in:

- A&E attendance
- Admission to wards (specific)
- Out patients appointments (specific)
- Lengths of stay (e.g. Short stays / Bed days)
- Readmissions to hospital

- Admissions to residential homes
- Admissions to nursing homes
- NWAS conveyance rates

These will be balanced by:

An increase in:

- The number of people who die in the place of their choice
- The number of people who use reablement services
- Identification of people in the cohort by primary care practitioner
- Activity in services in community settings
- The number of people in the identified group who have a key worker/co-ordinator
- The number of people in the identified group who have a care plan
- The number of carers in the identified group who are known and involved in the care plan

Measuring patient, carer and practitioner experience metrics need to be identified from those that have been used in previous integrated projects, and expanded where necessary, for example our previous use of Discovery Interviews, where patients experiences can be shared with staff and managers in order to redefine our care delivery.

7. Our system

In order to provide an integrated new service delivery model in a fundamentally co-ordinated and collaborative way, we are planning to develop the way we provide care as a system in South Manchester.

We are entering into negotiations in order to develop a method of delivery of care via an alliance contract between UHSM, Manchester City Council, the GP Federation and potentially, Manchester Mental health and Social Care Trust. It is anticipated that this arrangement may develop to form an integrated care organisation in the future.

The aim of this approach is to:

Bring providers together as an alliance around a defined set of services, to deliver shared improvements to health outcomes, outputs and resource expectations through a common performance framework:

- Formalise this through contractual means which brings meaningful risks and rewards to partners in the alliance

- Create an environment in which decision making, service development and material resource shift can happen fluidly.

8. Timescales

January 2014 – Initiation of South Manchester Living Longer, Living Better Provider Board chaired by Martin Vernon, Consultant Geriatrician

February 2014 – South Manchester New Delivery Model Design and Delivery Group to develop and agree and a road map for implementation

March 2014 – Commence the first phase of South Manchester New Delivery Model Implementation plan.

These are high level timescales and are dependent upon commissioners developing new contractual models to support implementation.

9. Costings

A finance workstream for the Living Longer, Living Better Programme is ongoing in parallel to the development of new service delivery models across the city.

Further work is required in order to identify service impact and shift and therefore the financial cost benefit analysis associated with it.

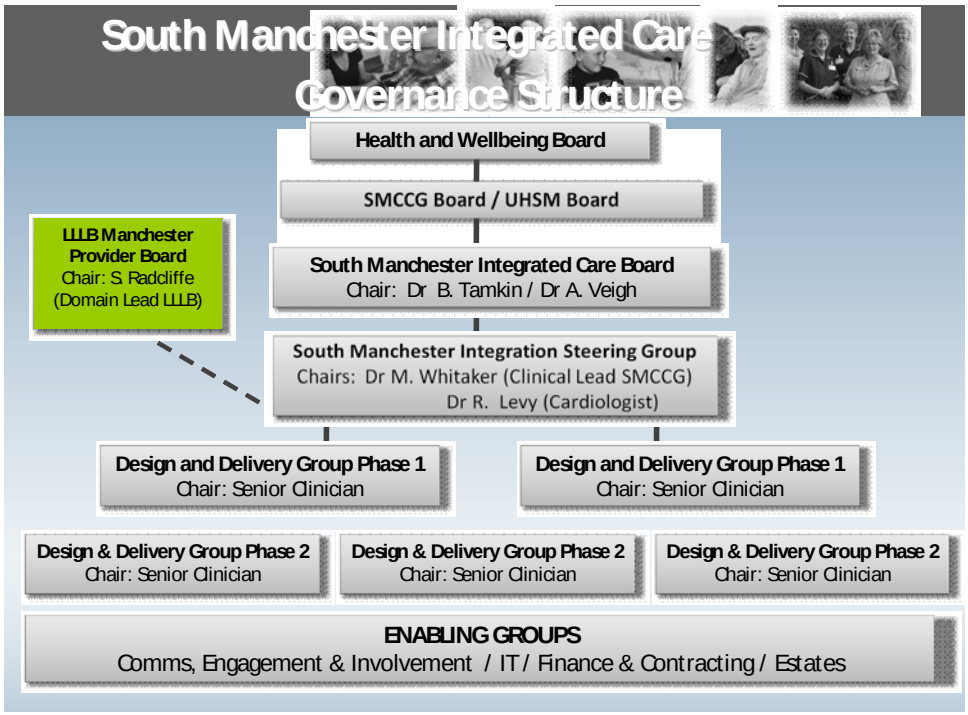
10. Engagement

Effective stakeholder engagement is a crucial ingredient for the success in the new care delivery model's implementation. Engagement so far has been with those stakeholders who have a direct 'interest' in the programme or influence over its delivery. This includes commissioner and providers, clinicians, voluntary and community sector organisations, front line staff delivering services as part of the integrated care pilots, and elected members.

The challenge now is to engage a much wider audience of stakeholders in the design and implementation of new delivery models.

Since embarking on the design of new care delivery models significant engagement has taken place reaching a wider audience of over 30 service providers who operate within south Manchester and in a very short period of time. Service providers have contributed with their ideas, aspirations, expertise and knowledge to a series of design sessions held in December 13, see appendix 2 for attendees. The outcome from these energising events has been the production of this document.

Our governance framework for integrated care in South Manchester, see below, provides the shared leadership across partner organisations to drive our strategy for engagement across a wider range of audiences in south Manchester, as well as creating an arena where meaningful engagement can take place with all interested parties locally.



We plan to establish a Living Longer, Living Better Provider Board within our existing governance arrangements to oversee the implementation of the new care delivery models from an operational perspective. This operational group will include the hospital, social care, community and voluntary sector as providers of services.

Meaningful engagement of people and their carers is also vital. In December, a city wide patient and carer's engagement event took place. The event created an opportunity to start the process of meaningful engagement with the people whom we want to benefit directly from our new care delivery models. The event was well attended by patients and carers.

A further session is planned for February 14 to start the process of co- production with patients and carers, and it will be ongoing thereafter. In south Manchester we will strengthen our engagement with patients and carers further by widening the scope of our south Manchester Integrated care communication and engagement group to encompass this within their strategy and plans. We will involve patient and carer for surveys, focus groups, interviews and diaries.

11. Key Risks

There are a number of risks that have already been identified by the south Manchester provider design groups which need to mitigate against. In particular these are:

- The ability of commissioners to contract with provider organisations in a different way to the current contracting processes and practices those are in place within the timescales.

- The resilience of provider organisations to work collaboratively together in new ways that will bring above considerable change, and impact upon some provider organisations directly, and on others indirectly.

- The timescales for design, development and implementation are compressed and extremely challenging.

- The pioneering status of this work does mean that there is limited experience or evidence to draw upon with a similar level of ambition for Manchester as that which is articulated by the Living Longer Living Better vision and strategy.

- Pump priming monies are likely to be required for new care model services to be implemented.

- There is a risk that the existing capacity and resourcing levels of provider organisations is stretched and therefore this will limit the pace at which development and implementation proceeds.

- The implementation of new service delivery models will impact significantly upon the resource of primary care and GP providers. There is a risk regarding their capacity to respond.

- The Care and Support Bill 2013 and its potential significant financial implications may impact on the affordability of Living Longer Living Better and the financial envelope to deliver new care delivery models.

Appendices

Appendices available on request from the Committee officer

A healthier Manchester – strategy for communicating out of hospital services to partners and stakeholders

Phase 1 - January 2014

Version 0.6

Summary

The Living Longer Living Better programme, which will transform out-of-hospital services in the city, is taking shape. Governed by the city's health and wellbeing board, it will mean all the organisations responsible for health and care in the city working together to deliver integrated services. These will ensure that local people receive high quality, personal services which support them to manage their own health and well-being, and live long, healthy lives.

With the consultation around the work to reconfigure hospital services – Healthier Together – planned for May 2014, there is a need to communicate what out-of-hospital services will look like to staff in partners organisations in the first instance, and then the public.

This strategy has been prepared in conjunction with senior communication staff at the CCGs, Acute Trusts, and Mental Health Care Trust in Manchester. We are also liaising with the team responsible for comms around the Healthier Together hospitals programme, to ensure consistent messages and co-ordination across Greater Manchester where appropriate.

Scope

This strategy looks at phase 1 of communication around the programme - with immediate partners, stakeholders and their employees. It deals with communication to broad audiences, and tools will be produced to support this. In some cases, partners will need to add local information to the materials produced to make them even more relevant to their organisation, and particular teams. There is also an aspiration for this to be a conversation, gathering feedback from interested parties on aspects of the programme which can be influenced, and where input is needed to inform design. This strategy does not cover all the communication required *between* stakeholders, which should happen as an ongoing part of the project. A second Phase of communication is planned, probably starting in March 2013, with wider interest groups and the public, and this will continue as the programme takes shape and plans are developed and tested with users and the public.

The communication around Living Longer Living Better will be split into 4 different phases:

Phase 1: Internal Stakeholders – January/February 2014
Phase 2: External Stakeholders – March /April 2014
Phase 3: Healthier Together led Public Consultation – June 2014
Phase 4: September 2014 onwards – continuing communications and engagement with all stakeholders to inform and engage them in the progress of our work.

Roles and responsibilities

Partner plans will need to clearly identify responsibilities around individual communication activities. A media protocol will be prepared and agreed between partners which will set out where media queries will be handled and/or who spokespeople will be depending on the nature of queries.

Where we are now?

New Delivery Models for future services are currently being developed. For this reason, it will not always be possible to tell people exactly what services will look like in future. However, where possible, real examples of how things are already being done in the new way to improve effectiveness, or increase resilience/independence across the city will be used, using stories to simply explain what made them work and what it means to real people.

Partners have already been communicating elements of the Living Longer Living Better programme to their staff. A number of other projects are also happening alongside Living Longer Living Better which either contribute to or are part of the delivery of this programme. These include:

- The review of hospital health and care in Greater Manchester (Healthier Together)
- The review of Mental Health services for Manchester
- The redesign of the Healthy Lifestyles service
- The Manchester Cancer Improvement Partnership
- CCG Social Isolation Grant scheme

Where possible, the vision and mission of these programmes should be aligned, and share common messages about what they will mean to the people of Manchester.

Insight

For a number of years, the LLLB partners have been collecting information from the public and service users about their experiences of, and preferences for, health and social care services in Manchester. This has been collated and used to inform the initial stages of this work. Additionally, a number of pieces of engagement exercises with staff and service users have already taken place as part of the work to involve users and staff in shaping what future services will look like.

Real examples of projects designed to increase independence and resilience, where they have worked and what are the elements that made them work (told as stories) will be vital in getting people at all levels of the organisation to properly understand the concept and how it works.

Communication Objectives

Objectives of communication

- inform / reassure partners, stakeholders (and in Phase 2, the public) by giving them a picture of what services around health and wellbeing will look like for Manchester residents in the future.
- minimise controversy and confusion around the changes to health and social care in Manchester, and build confidence in them.

- explain the reasons behind the change
- highlight the benefits of the changes for the public
- highlight any benefits of the changes for partners and their employees
- help staff understand the change, and where possible / appropriate make them ambassadors for it.
- to tailor messages where possible / appropriate to groups of staff so that they are as relevant as possible
- understand stakeholders' and the public's experiences and preferences for health and well being services in the city
- use real examples and stories about people to bring this to life.
- address concerns / issues / barriers within organisations who are stakeholder, and their workforces
- mitigate risks around the various programmes
- to provide context for the impending conversation / consultation around changes to hospitals (Healthier Together)
- to give managers communication tools which will help them explain and support the integration process

Audiences

The partners / stakeholders who make up the audiences for this first phase of activity will fall into the following broad categories:

Senior leaders
Senior clinicians
Senior managers
Elected members
MPs
Unions
Key committees (including governors)
All staff in the council, acute trusts and Mental Health Trust
NHS England
Voluntary sector (including user groups)
GP practices
Healthier Together
NWAS
Clinical networks
Manchester Alliance for Community Care
LMC /LPC / LDC / LOC
Healthwatch
Partner Organisations' public engagement mechanisms

The council, the acute trusts and the mental health trust are all preparing individual roll-out plans for how to reach staff and partners of their own organisations, starting in January.

Key Messages

A one-page summary of the main messages and examples of current practice which will be used to bring them to life is attached at the end of this document.

Broad messages for everyone:

- Where we are now and why
- Why are health and social care changing / why do we have to change?
- What are the benefits?
- What will it mean to me / what do you want me to do?
- What will health and social care look like in the future?
- Timescales / milestones

And within these…

- People in (some parts of?) Manchester have the poorest health and lowest life expectancy of anywhere in England – we want to change that
- Our health system is more than 60 years old, and hospitals were built when life expectancy shorter and biggest killers were infectious diseases
- There is a variation in outcomes for people attending different hospitals in Greater Manchester. In the future, health service providers, the council and partners including the voluntary sector will be delivering health and care which meets consistent standards across the city. *(N.B. re when standards will be in place to be communicated).*
- The current system is unaffordable as a result of reducing public sector funding and increasing costs of care
- Health care in 2014 doesn't all need to be hospital based and it's sometimes better for the people being treated if it isn't
- We want to invest in high quality services closer to home, and make better use of community buildings as a location for these
- Health and social care services will be joined up around residents and their families, so they'll simpler to understand and deal with
- When people do need a hospital, they have a right to expect the highest standard of clinical care
- No hospital in Manchester will be closing but they will change what they are doing, and in some cases community services may be delivered on a hospital site
- We want to be more proactive - taking early steps before urgent help is needed
- The aim is to look after whole person, not focus on 'conditions'
- More use will be made of new technology / new treatment
- Measuring success will be more about the positive impact which the changes have on people, not about numbers treated etc.
- Where possible we'll put people and their families in charge – self management, shared decision-making
- Longer term, we want to help people to keep themselves healthier – prevention as well as cure.
- Where people should be going to access health and social care in the eantime

The suggested approach for talking about how the services will look in five years is to group the changes i.e. what will be different in the home, in the community, in hospitals.

Channels

Channel plans are being produced for each key partner (trusts and MCC) which look at comms to stakeholders and staff.

Evaluation

Manchester City Council is committed to demonstrating the value and effectiveness of all its communication campaigns, including return on investment and value added. For this reason it is vital that wherever possible, methods of evaluation are identified before activity is carried out, and information is shared with comms to allow evaluation of the impact of communications carried out.

Next steps

Look at materials which may be useful in supporting communication around the programme, including:

- Produce a key message control 'same story' document to outline language to use when talking about the changes (and what not to use) plus how to describe it in a phrase, a sentence, a paragraph, 300 words etc. This will help to get consistent messages out across partners around the programme.
- Prepare a PowerPoint presentation and speaker notes for use with and by managers to explain what future services will look like, and giving real examples of where things are already changing and what it will means to people who need health and/or social care.
- Prepare a set of short films case studies – 'stories' - to show some of the ways that services have empowered residents and increased their independence and/or resilience, and what benefits this has brought to Manchester people.
- Prepare a set of Frequently Asked Questions and answers to help get consistent messages out and for use by those delivering the messages face-to-face.
- Develop a detailed action plan to take this communication strategy forward, allocate ownership and agree timescales.

Action plan

TIMING	CHANNEL	ACTIVITY	RESPONSIBILITY
Tue 10 December	City Wide Leadership Group meeting	Revised comms strategy presented	VB/NG
Thur 5 December	Meeting	Trust leads presenting internal channel plans for roll-out of messages to internal audiences and	Comms leads

		partners	
Through December	Various patient and GM Integration events	General messages around the changes and opportunity for people to feed back. Briefing of Chief execs	City Wide Leadership Group/comms leads
Wed 18 December	Exec Meeting	Strategy presented, detailing the messages for stakeholders, channels and timings .	VB/NG
8 January	Emergency Exec meeting		
22 January	Health and Wellbeing Board	Full plans and materials presented to board for immediate roll-out.	VB/NG

Separate plans for each partner organisation communicating the changes to its staff and key stakeholders are available.

A healthier Manchester – Why we need to change

Key Messages: People in Manchester have the poorest health and lowest life expectancy of anywhere in the country – we want to change that

Our health system is more than 60 years old, and hospitals were built when life expectancy shorter and biggest killers were infectious diseases

There is a variation in patient outcomes across different hospitals in Greater Manchester

The current system is unaffordable as a result of increasing costs of care

Health care in 2014 doesn't need to be hospital based and is often better for people if it isn't

We want to give people in Manchester the best quality health services close to their home

We want to improve services for all our population, including children and young people.
We will work closely with carers to make sure they are supported and included in care planning

Services where they're needed, when they're needed

At home

Services will be joined up around you and your families, so they'll be simpler to understand and deal with

We want to be more proactive and take early steps before urgent help is needed.

We will make more use of new technology / new treatment.

Wherever possible we'll put you charge, helping you to be as independent as you can be.

We want to help you to keep yourself healthy

We'll measure success based on health outcomes for you, not on numbers treated.

In the community

Where appropriate, care will be given in the home or in the community where people live.
If you have a long term condition, there will be one team looking after you a named individual co-ordinating your care
You will be able to get clinical advice 24 hours a day, 7 days a week
You will be able to see someone at your GP practice on the same day if you are urgently in need of treatment
We will make sure that your mental health is looked after as much as your physical health
Services in your community will help you to be healthy and support you if you are lonely

In hospital

When you need hospital care, it will be there for you
Hospitals will work together to make sure that you are seen by doctors who are the best at treating your illness or injury
No hospital sites will close, but they will change what they do

At home examples

People supported to die at home when they choose to
Telephone and Skype appointments with professionals
Equipment and minor adaptations to support independent living
Electronic medication – fluids / IV antibiotics
Community alarm and telecare solutions
Equipment and minor adaptations to support independent living
Access to directory of local community services close to home

Feedback sought: Workstream specific

Community examples

Single teams, with a range of professionals, looking after those at risk of going into hospital
Community teams supporting people in crisis
Grants to voluntary sector organisations to address social isolation and loneliness in older people
GP practices open longer and providing greater range of services
New mental health services based around needs of patients
Better community treatment and care for those affected by cancer
New services to help people live healthy lives
Creating community health facilities on the North Manchester General Hospital site

Feedback sought: Workstream specific

Hospital Examples

Stroke
Major Trauma
The Christie

Feedback sought: In line with Healthier Together consultation