Manchester Health and Wellbeing Board
Report for Resolution

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

Subject: Better Care Fund

Report of: Clinical Commissioning Group Chairs and the Interim Strategic Director for Families, Health and Wellbeing

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Summary

The purpose of this report to set out the Better Care Fund (BCF) and the approach being taken by Manchester Clinical Commissioning Groups and Manchester City Council to use the BCF to support the integration of NHS and social care delivery in line with the Living Longer Living Better Strategy.

Recommendations

The Board is asked to:

- Approve the use of the average historic performance trend for the most deprived decile (10%) of local authorities in England as a starting point from which to set out the performance measure for Manchester for 2015/16 and delegate agreement of the metrics of the performance measures to the City Wide Leadership Group. Success on achievement will affect the payments by results payment in the BCF for 2015/16.
- Approve the contribution to the Local Development Fund by CCGs and Council in the final BCF submission once agreed.
- Approve a pooled budget for 2015/16 under Section 75 agreement to be hosted by the Council.

Board Priority(s) Addressed: 1 – 8

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Background documents (available for public inspection):

Better Care Fund Guidance: NHS England 2013

1. Introduction

The Better Care Fund (BCF) (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. The Fund identified nationally £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the BCF in 2015/16. In December 2013 the Government introduced the BCF guidance, templates and set out the allocations to local areas.

The Health and Wellbeing Board is required to sign off the plan for BCF for submission by 14th February 2014. The plan must be developed as a fully integral part of the CCGs wider strategic and operational plan, but the BCF elements must be capable of being extracted to be seen as a stand-alone plan. The BCF aims to set out:

- The ambition for the BCF
- That the national conditions have been achieved in accessing the fund
- The performance goals and payment regimes that have been agreed in each area
- The shared risk register to include the agreed approach to risk sharing and mitigation to include the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned.
- That CCGs and Council will engage from the outset with all providers to be affected by the use of the fund in order to achieve the best outcomes for local people and to help manage the transition to new patterns of provision.

2. The Better Care Fund Allocation

For 2014/15 the BCF included an additional £2.2m transfer from the NHS to the Council. The requirements for the use of this funding is to support adult social care, which also has a health benefit, having regard to the Joint Strategic Needs Assessment and agreeing how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer. NHS England will only pay out the additional funding to councils that have jointly agreed and signed off two-year plans for the BCF. Councils should use the additional funding in 2014/15 to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan.

For 2015/16 the total BCF is £42.1m which includes a further transfer of £20.4m into the BCF. The allocation is not new money to the local economy, £19.5m is committed to existing ongoing spend within the Council and CCGs and the transfer from health £20.4m is expected to be released from commissioning for hospital services. Around 25% of the 2015/16 BCF allocation will be based on progress with

achieving agreed performance targets based on baseline measures set out by the Department for Education.

The BCF is also linked to new duties that come in from April 2015 as a result of the Care Bill, resulting from new entitlements for carers and the introduction of a national minimum eligibility threshold as well as better information and advice, advocacy, safeguarding and other measures in the Care Bill.

In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between the CCGs and Council. Funding will be routed through NHS England and a condition of accessing the money in the Fund is that CCGs and Council must jointly agree plans for how the money will be spent. These plans must meet certain requirements to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

The table below sets out the BCF allocations for 2014/15 and 2015/16 and for comparison includes the detail on existing funding in 2013/14.

Better Care Fund Allocation	**2013/14** **£000**	**2014/15** **£000**	**2015/16** **£000**
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**

3. Local Development Fund

BCF allocations specify only the minimum amount of funds to be included in pooled budgets. The CCG and Council can extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.
It has previously been proposed to the Executive Health and Wellbeing Group to set up a Local Development Fund to support:

- The first phase implementation of Living Longer Living Better (LLLB) which creates the evidence for decommissioning (particularly, but not solely in the acute sector)

- The continuation of the three pilots
- Capacity costs needed for the implementation of LLLB
- Form part of the funding for the Alliance linked to achievement of agreed performance metrics.

The above would create the funds to go into a recyclable investment fund which drives the scaling up and incremental narrowing of the gap between risk and confidence. By funding the first phases of implementation of LLLB evidence will be created of actual impact of out of hospital integration on demand for other services including hospital and residential care. That provides the evidence for decommissioning and moving some of the resulting savings to invest in for the scaling up of out of hospital integrated services.

Work is being carried out to see how this could be funded. Areas that are being explored include a contribution from the CCGs, City Council funding including potential investment of Public Health monies into the implementation of LLLB. In order to satisfy the requirement of the BCF it is necessary to set up a pooled budget under Section 75 for 2015/16. The BCF could include the Local Development Fund including the element of BCF supporting implementation of LLLB. It is recommended that the Council host the fund on behalf of partners.

4. Better Care Fund submission template

The Department of Health has requested that Health and Wellbeing Board sign off a template for the Better Care Fund by 14th February 2014. This will be reported for approval to the Health and Wellbeing Board meeting on 22nd January 2014. The template has been populated by the LLLB City Wide Leader Group (CWLG) informed by the development of the new delivery models for the LLLB programme.

The BCF submission is attached in appendix 1. It should be noted that proposals for the use of funding will also be subject to sign off through the Council's and CCGs budget process.

5. Recommendations

The Health and Wellbeing Board is asked to:

- Approve the use of the average historic performance trend for the most deprived decile (10%) of local authorities in England as a starting point from which to set out the performance measure for Manchester for 2015/16 and delegate agreement of the metrics of the performance measures to the CWLG. Success on achievement will affect the payments by results payment in the BCF for 2015/16.
- Approve the contribution to the Local Development Fund by CCGs and Council in the final BCF submission once agreed.
- Approve a pooled budget for 2015/16 under Section 75 agreement to be hosted by the Council.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Manchester City Council**
Clinical Commissioning Groups	**North Manchester CCG**
	Central Manchester CCG
	South Manchester CCG
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**22nd January 2014**
Date submitted:	**14th February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£7,321,000**
2015/16	**£20,640,000**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	North Manchester CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Central Manchester CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>
Signed on behalf of the Clinical Commissioning Group	South Manchester CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	Manchester City Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Manchester Health and Wellbeing Board have responsibility for this work, signing off the direction of strategy and specific plans and implementation since 2012. Provider representation on the HWB includes Manchester City Council (MCC), Central Manchester Foundation Trust (CMFT), Pennine Acute Hospital Trust (PAHT), University Hospitals South Manchester (UHSM), Manchester Mental Health and Social Care Trust (MMHSC) and the Manchester Alliance for Community Care (MACC).

In addition these organisations have been closely involved in all aspects of the design of the plan of work and have been active members of the Citywide Reference Group that have written the Business Cases and care plans.

In October 2013 a city wide provider partnership was established and meets weekly. Its invited membership is made up of representatives from the following organisations

- CMFT, city wide leadership team, lead for integrated delivery models

- UHSM, city wide leadership team, lead for estates
- PAT, city wide leadership team, lead for workforce
- MHSCT city wide leadership team, lead for evaluation
- MCC city wide leadership team, lead for system reform
- Central Manchester GP Provider Organisation
- South Manchester GP Federation
- North Manchester GPs
- Manchester carers Forum
- Manchester Health Watch
- Go To Doc – Out of Hours provider
- MACC
- North West Ambulance Service
- Project Support Provided from CMFT

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

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

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

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.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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).

There was a resident feedback event held in Manchester in December 2013 on the co-production process as part of the new delivery model design work. 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

Further consultation around the work to reconfigure hospital services – Healthier Together – is 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.

A communication 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 communications around the Healthier Together hospitals programme, to ensure consistent messages and co-ordination across Greater Manchester where appropriate. The communication objectives for the strategy are to:

- 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

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Strategic Outline Business Case	To be completed
Business Case	
Care Models	
NDM	

JSNAs	

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

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.

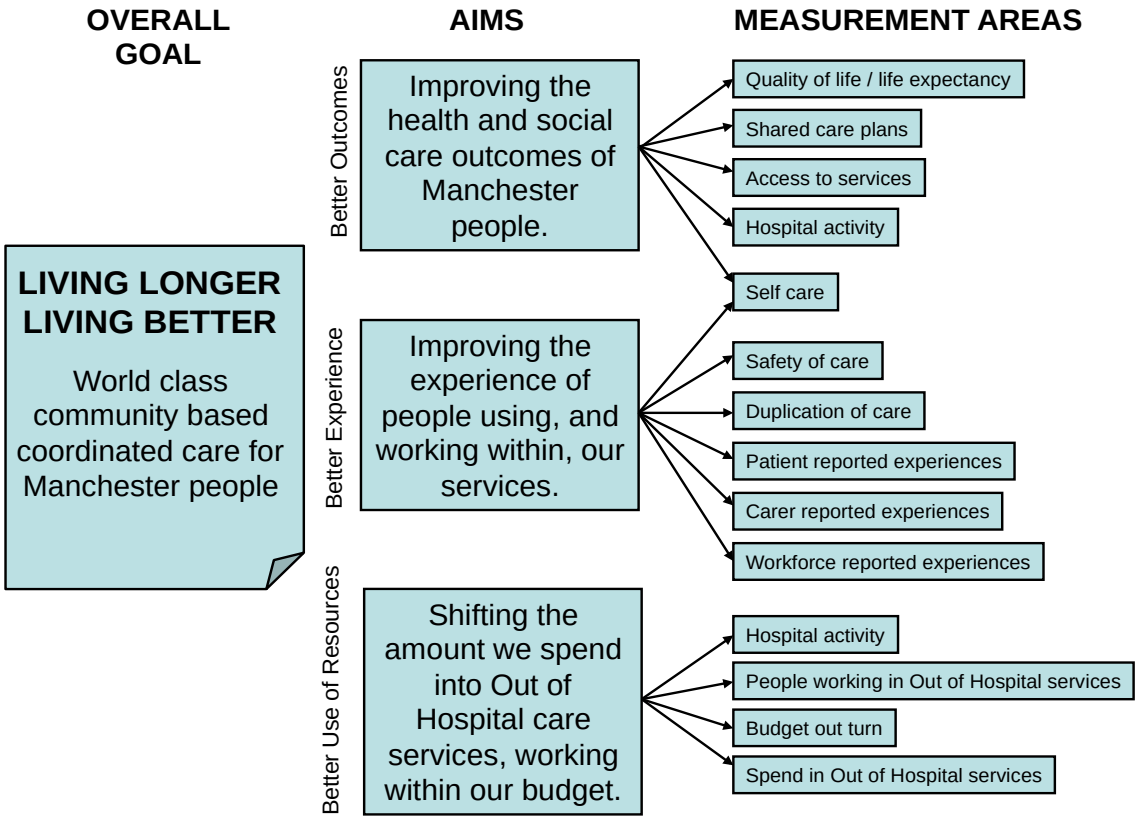
Integrated care teams are helping people discharge more safely and sustainably from hospital, linking to specialist services such as reablement and intermediate care to help people live more independently and reduce the risk of returning to hospital. Similarly, community falls teams, an urgent response 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.

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.

The Living Longer Living Better programme is Manchester's programme of reform for delivering integrated care. Taking the case for change and the GM context into account, including Healthier Together and Primary Care, there is a clear narrative for Manchester's integration programme, the Living Longer Living Better Programme (LLLB), which sets out the rationale for our approach, outlined below.

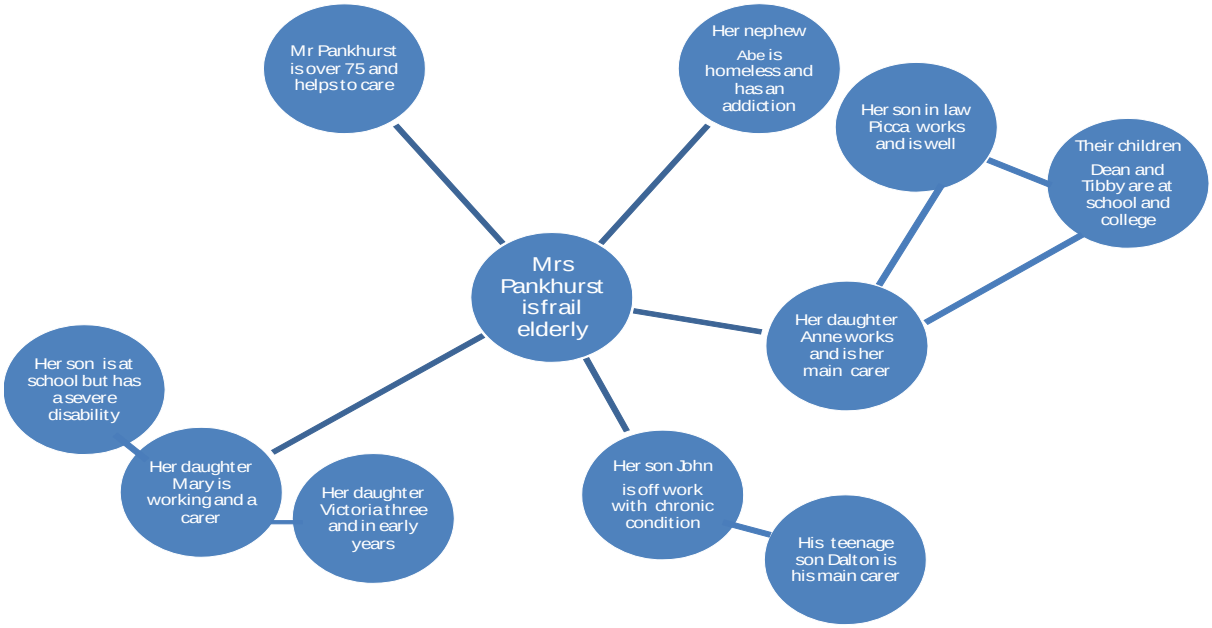
i. Integrated health and social care is one part of the growth and reform plans in Manchester. As well as a coherent out of hospital offer for our residents, we must also build Manchester's offer of world class health sciences and health research, which will translate into economic growth for the City.
ii. Integrating health and social care, and dealing with the financial and clinical challenges of the acute sector is complex, sensitive and time consuming. But it is inherent to our ambition for the City and its residents, and is best led by Manchester rather than being imposed.
iii. There is a "burning platform" of significant reductions in Council and NHS funding at a time of increasing demand pressures. "Do nothing" is not an option.
iv. We need the best, mutually supportive set of proposals achieving integrated health and social care and a safe and financially viable acute sector in Manchester.

v. There needs to be confidence in the scale and consistency of out of hospital integrated care models before we implement changes at scale to acute services. Our residents must be about to 'touch and feel' what integrated care means for them, rather than a nebulous concept.
vi. Out of hospital integration has to happen at scale and speed if we are to meet the fiscal and demand challenges facing Manchester.
vii. In Manchester we have invested significantly in developing jointly owned and shared plans for out of hospital care – involving not only commissioners but providers, patient groups and the voluntary and community sector. This will help speed the implementation of the new care models.



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

Meet the "Pankhursts" in 2013



The future: 2020

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

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

"Mrs Pankhurst's" daughter Anne will be offered co-ordinated support and

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

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

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

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

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

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

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

We will deliver this by:

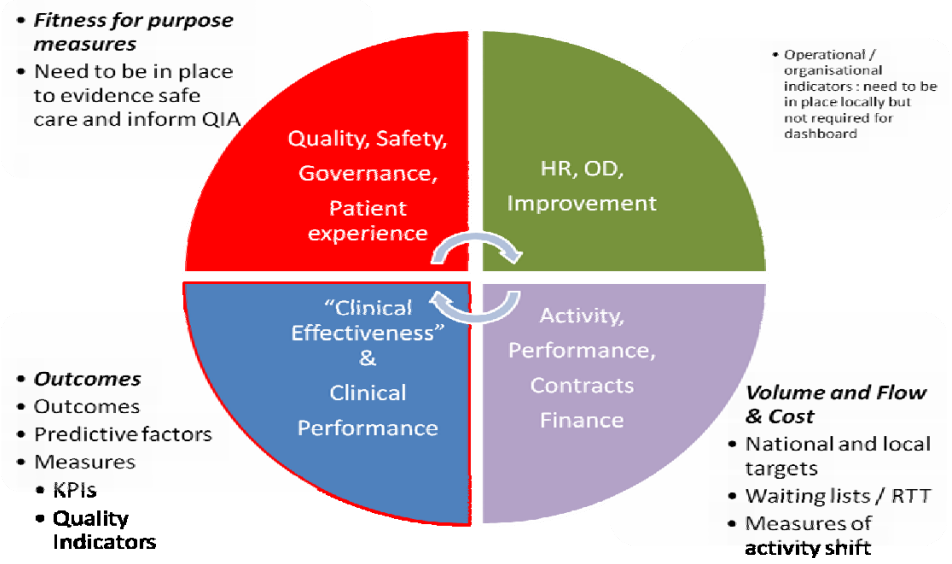
- Empowering and equipping our Workforce with the skills to deliver co-ordinated care.
- Connecting systems and people with up to date information.
- Ensuring we have quality buildings providing multi agency support and care.
- Creating a movement for social change, engaging with the whole Manchester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

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

In order to capture the breadth of impact that the integration 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 integration 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.

The diagram below provides a visual illustration of this approach.



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 integration 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

The first stage of the work has focused on agreeing the high level aspirations of the integration 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 integration 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

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.

Financial measures

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.

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 new delivery models during 2014/15

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

New contracting arrangements are in development in each of the three CCG areas 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. 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.

c) Description of planned changes

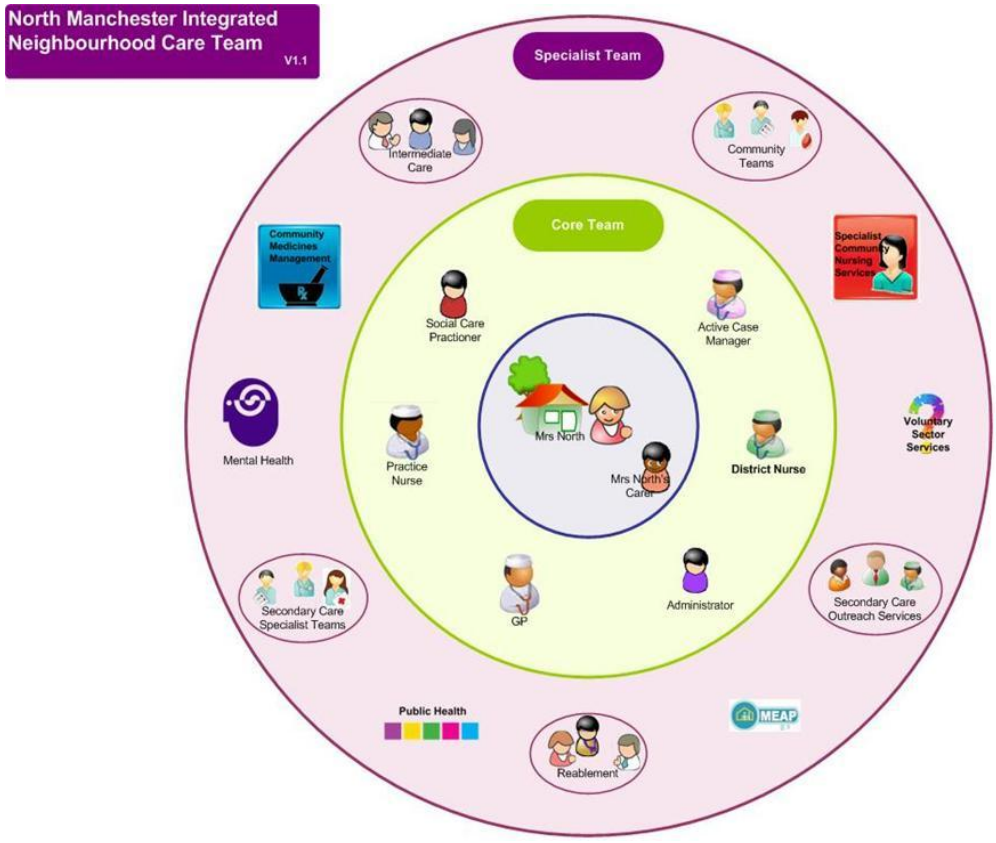
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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 38 GP practices across the City, with core teams comprising of a social worker, GP, practice nurse, nurse practitioner and health care support worker, including a mental health practitioner in some localities.
- 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.



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

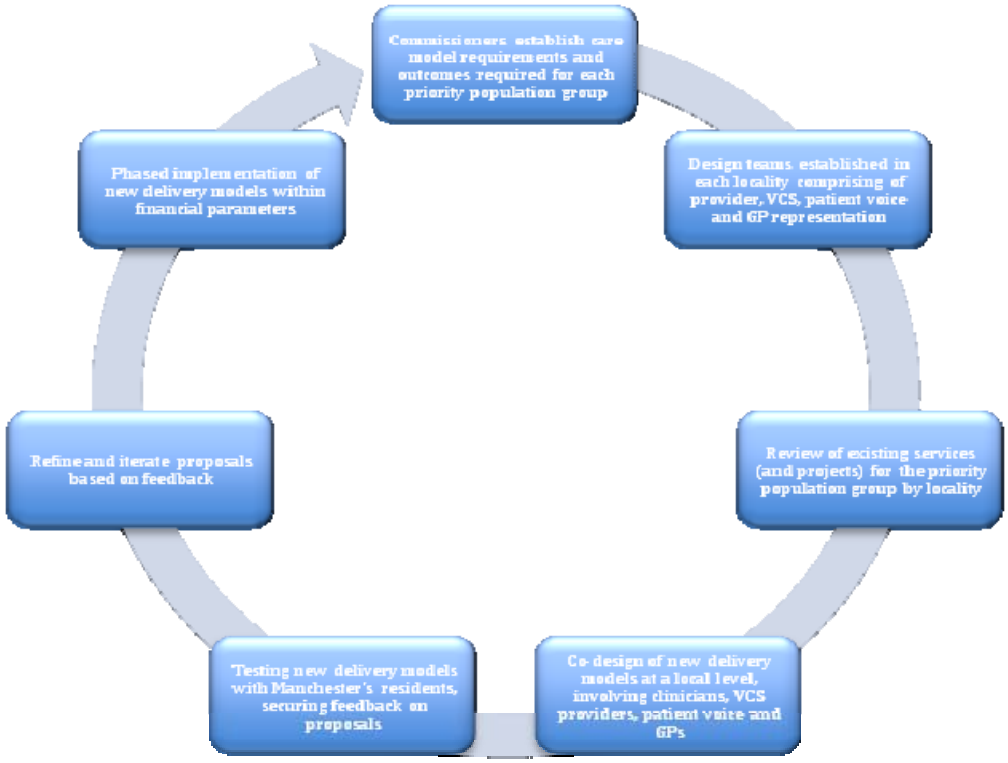
- To scale up and spread the existing integrated care models operating in Manchester described above, covering for example all GP practices, through 2014 and beyond, capturing the evidence of what works. This accounts for committed investment of £5m in 2014/15.
- To implement innovative new delivery models currently in the design phase (described below and in the annexes) on a phased basis from 2014/15 onwards. £2m has been allocated to the phased implementation of these models, with further detailed plans to be submitted to the Board in March 2014.

Eleven population sub-groups have been identified by the City Wide Reference Group, which provide a greater level of granularity with which to develop the new delivery models. Five of these have been identified as priority groups for the development of the first set of integrated care models. The sub-groups are

	Sub-group name	Rules	Dominates over:	Priority groups
1	**End of life care - Adults and children**	1. Age: 0+ 2. On Palliative care register	All	✓
2	**Long term conditions - Adults**	1. Age: 19 years + 2. On one or more of	Maternity Good health -	✓

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

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

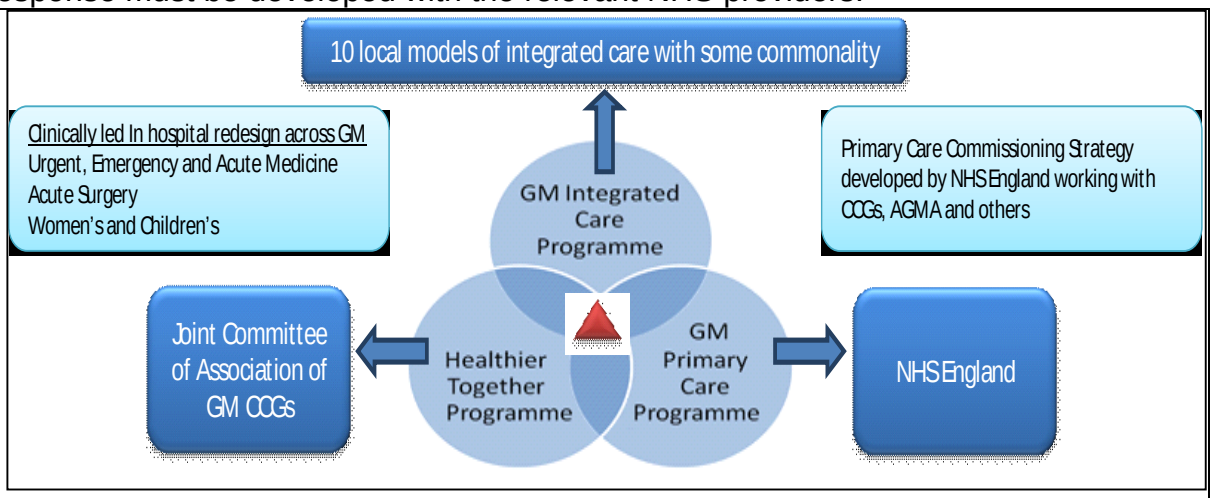


This approach is underpinned by the following principles:

- 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. This will ensure that the models align with local plans such as the JSNA, JHWS, CCG Commissioning plans and LA plans.
- As a result, the phasing of the implementation of the new delivery models will differ across the city.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.



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. 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

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.

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.

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.

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.

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.

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.

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.

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).

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.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

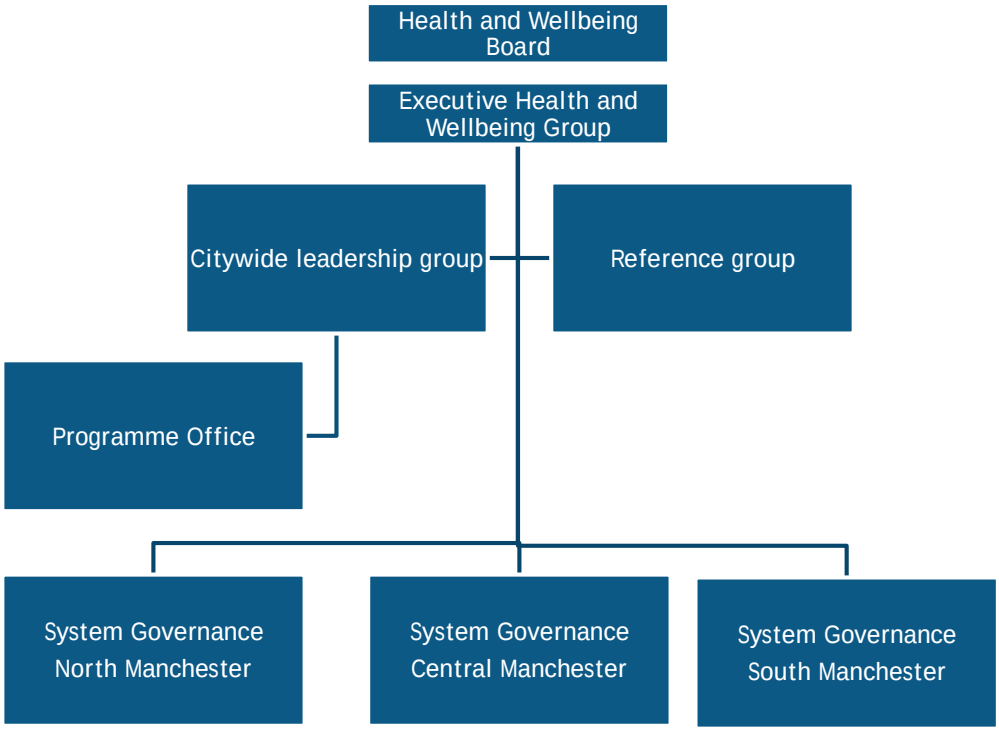
The Integration programme (LLLB) is accountable to the statutory Manchester Health and Well-being Board, through the Executive Health and Well-being Group which consists of all of the chief officers and chief executives of the organisations in the programme partnership.

Reporting to the Executive Health and Well-being Group, and responsible for the production of this strategic outline case, is the Citywide Leadership Group. The Citywide Leadership Group is advised by the programme's Professional Reference Group, which also reports to the Executive Health and Well-being Group. The

programme senior responsible owner is the Strategic Director of Families, Health and Well-being, Manchester City Council.

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

The governance arrangements are illustrated in the figure below:



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Adult Social Care budgets have faced a number of challenges including the need to make significant savings in the climate of rising demand. There is a need to avoid both making budget cuts that impact on the ability to more sustainably reduce demand in the longer term and that jeopardise the greater gains that can be made across the system through integration and the community budget work.

Please explain how local social care services will be protected within your plans.

As the transfer of funding from the NHS is included in the overall settlement for the local authority, the BCF allocation has £9.998m currently committed to the protection of adult social care in 2014/15. Funding will be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment.

The Local Authority will expect to fund the implications of the 'Care Bill' via the additional social care funds transferring from 1 April 2015 in respect of national eligibility criteria and carer assessments. Planning for local care services will prioritise the development of services that:

- Provide universal services intended to prevent, reduce or delay needs and information, advice and guidance.
- For those whose need cannot soley be met through universal services, carry out an individual assessment or carer assessment considering benefit from universal or local services.
- Development of integrated care and support plans to reflect personal choice and set up personal budget for those that meet eligibility criteria for social care services.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Manchester's Health and Wellbeing Board is committed to the delivery of seven-day health and social care services across Manchester. An underlying theme of Manchester's integrated health and social care programme, Living Longer Living Better, is the delivery of the right care, at the right time and place. This means ensuring safe access to health and social care services over seven days and across different settings of care.

Each of the three CCGs, the Local Authority and NHS Acute Providers are at

different stages in the development of seven day services, recognising the different health economies, population groups and settings of care in the City. The Health and Wellbeing Board has agreed that by [insert date], local implementation plans for seven day services will be approved for each locality, ensuring consistency across Manchester.

This will build on good practice already being delivered to safely discharge patients and prevent readmissions. Examples of seven day delivery already in place in the City include: [to review]

- 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 GP practices across the City,
- 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

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Commissioners and providers in Manchester, including the Local Authority, are using the NHS Number as the primary identifier for correspondence across all health and care services. Similarly, as part of the Living Longer Living Better programme, Manchester is implementing on a phased basis the use of a single care record, that can be used across different providers within appropriate clinical governance and data governance requirements.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Not applicable

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We can confirm the above

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG

Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Manchester has an established information governance framework which covers both NHS and Local Government IG requirements. It facilitates the sharing of data across health and social care partners in the City and has supported the implementation of integrated care in North, Central and South Manchester.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

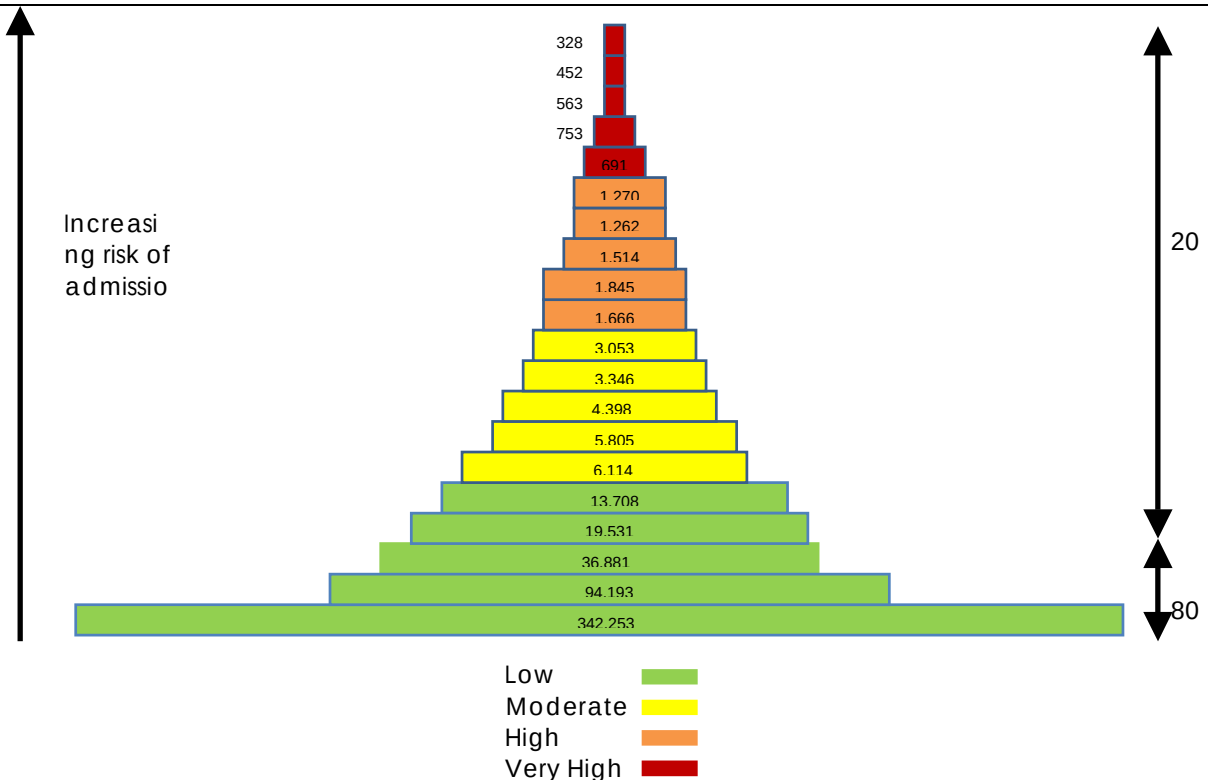
The Health and Wellbeing Board can confirm that patients identified as being at high and very high risk of admission will have a lead professional as part of a multi-disciplinary team to assess, plan, deliver and monitor their care.

Multi Disciplinary Teams in the community operate out of 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. The lead will be allocated to the most appropriate professional who is working with the resident/patient.

This model of delivery is being implemented across the city on a phased basis, with 38 GP practices currently in place with further practices being added on a monthly basis.

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 to live 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.

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 using the Combined Predictive Model). This highlighted the considerable impact of a relatively small proportion of the population.



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**	3. Age: 0+ 4. On Palliative care register	✓
2	**Long term conditions - Adults**	3. Age: 19 years + 4. On one or more of the LTC register	✓
3	**Frailty / dementia - older people**	3. Age: 65 years + 4. Secondary care activity including: - Dementia - Broken bones in the upper body - Falls	✓

4	**Complex needs - Adults**	3. Age: 19 years + 4. Presents two or more of:	✓
5	**Long-term conditions - Children**	3. Age: 18 years + 4. On one or more of the LTC	✓
6	**Carers - Adults and children**	N/A for current modelling purposes	
7	**Good health - older people**	3. Age: 65 years + 4. Included in no other group	
8	**Early years (0-4)**	3. Age: 0-4 years 4. Included in no other group	
8b	**Maternity**	3. Women who have given birth	
9	**Good health - children**	3. Age: 5-18 years 4. Included in no other group	
10	**Staff - Adults**	N/A for current modelling purposes	
11	**Good health - Adults**	3. Age: 19-64 years 4. Included in no other group	

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, with targeted care models being developed and delivered for each.

	Long term conditions – Children	6,657	1.2%

In January 2014, there are 943 patients at risk of escalating needs with a lead professional in place. This is increasing on a monthly basis as integrated care delivery is extended across the City.

st updated: 13/11/06

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

ID	Category	Status & Date	Risk Description	L	I	Risk Score	Mitigation	Outcome	Updated	Risk Owner
1	Delivery of Strategy	Open	The development of our business case for LLLB sits within the context of three overlapping and dependent programmes of work at a Greater Manchester level – 1) LLLB as part of the GM integrated care programme 2) Healthier Together the GM hospital services programme and 3) Primary Care development programme from NHS England. There is a risk that these three programmes are seen and delivered as separate independent pieces of work, and that objectives are not clearly aligned	4	4	16	The LLLB programme is being developed within the overall GM integrated care programme. The strategic aims and strategies for the three pieces of work are being aligned in Manchester through the agreed priorities of Manchester's Health and Wellbeing Board. The city wide leadership team for LLLB is particularly focussed on ensuring primary care is part of, and not separate to, the new community based care models. As we develop and deliver our communication and engagement plans for both our workforce and externally to our patients			Exec HWB Group

ID	Category	Status & Date	Risk Description	L	I	Risk Score	Mitigation	Outcome	Updated	Risk Owner
							and customers, we will look to deliver a coherent and consistent message about what the changes mean for them, rather than the artificial boundaries of three interconnected programmes of work.			
2	Delivery of Strategy	Open	The structure of the health and care economy in Manchester is complex with three Clinical Commissioning Groups, four hospital trusts, the mental health and social care trust and Manchester City Council. There is a risk with this complexity that the LLLB strategy will be implemented and deployed differently through the three locality systems resulting in different service offers across the City.	5	4	20	As we move from strategy to implementation in the LLLB programme it is essential that the overall strategic accountability for delivery of outcomes for Manchester people remains a priority for the Health and Wellbeing Board and its executive groups. The evaluation framework that we put in place for the programme must be developed to ensure that we can measure and evaluate progress across the whole network to ensure improved outcomes are delivered consistently across the city.			Exec HWB Group

ID	Category	Status & Date	Risk Description	L	I	Risk Score	Mitigation	Outcome	Updated	Risk Owner
3	Finance	Open	The financial picture for public services in Manchester over the next few years is extremely challenging with budget reductions across the board for health and care services. There are clearly individual financial risks for each LLLB partner organisation which could create instability for the medium and long term strategic aims of the programme.	3	4	12	It is clear that the increasingly difficult funding picture for public services mean that potential financial uncertainties for all LLLB partner organisations will need to be managed. The cost benefit analysis and ongoing management must continue to be co-owned by providers and commissioners. Funding and contracting arrangements put in place must be sustainable for all institutions and partners involved.			Exec HWB Group
4	Governance	Open	The strategic development of Living Longer Living Better in Manchester has been contingent on the relationships between commissioning and provider organisations in the City. The whole scale change of how health and care will be delivered in the future needs collaborative leadership from all sectors	4	5	20	Over the next 6 months the governance structures that have been put in place to support delivery of the LLLB programme must be looked at and considered in terms of supporting the next five to ten years of sustainable change in our health and care economy. It must be ensured that we have appropriate forums			Exec HWB Group

ID	Category	Status & Date	Risk Description	L	I	Risk Score	Mitigation	Outcome	Updated	Risk Owner
			of the system. As we move into the implementation phases of this programme, there is a risk that these collaborative relationships will be strained or even break down, which could critically damage realisation of our strategic aims.				and groups in place to tackle issues that arise and ensure implementation of our objectives is achieved over the medium and long term.			

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Manchester City Council		16,671	*31,990*	*31,990*
CCGs		10,100	*#REF!*	*#REF!*
BCF Total		**26,771**	***#REF!***	***#REF!***

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)	20419	
	Maximum support needed for other services (if targets not achieved)	20419	
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Carers break and reablement	CCGs	*5,000*			*0*	*5,000*			
Social care transfer	MCC	*9,998*				*9,998*			
Disabled Facilities Capital	MCC	*2,967*				*2,967*			
Social care capital	MCC	*1,485*				*1,485*			
Integrated Care Pilot rollout	CCGs	*5,100*				*5,100*			
Care Bill implementation	MCC	*0*				*2,000*			
New Delivery Models	CCGs/MCC	*2,221*				*15,540*			
Total		***26,771***				***42,090***			

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		**Current Baseline (as at....)**	**Performance underpinning April 2015 payment**	**Performance underpinning October 2015 payment**
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	821.8	N/A	To be agreed by CWLG
	Numerator	400		
	Denominator	48430		
		(April 2012 - March 2013)		(April 2014 - March 2015)

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	63.4	N/A	To be agreed by CWLG
	Numerator	295		
	Denominator	465		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	215	To be agreed by CWLG	To be agreed by CWLG
	Numerator	855		To be agreed by CWLG
	Denominator	115040		
		April 2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*		To be agreed by CWLG	To be agreed by CWLG
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
[local measure - please give full description]	*Metric Value*		To be agreed by CWLG	To be agreed by CWLG
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*