Manchester Health and Wellbeing Board
Report for Resolution

Report to: Health and Wellbeing Board – 19 March 2014

Subject: Living Longer, Living Better: Progress Update

Report of: Citywide Leadership Group

Summary

This update follows on from the detailed reports provided to the Board in January on the Living Longer, Living Better Programme and the Better Care Fund submission.

Recommendations

The Board is asked to:

1. Note the progress of the LLLB programme since December 2013, in terms of development of business cases to support investment in the priority new delivery models
2. Support the proposals for investment of £10.2m from the LDF/BCF for 2014/15 linked to financial plans
3. Note that further proposals for investment into the models to support the implementation of the Care Bill from April 2015 are required to be considered at the meeting of the Health and Wellbeing Board on 10th September
4. Note that investments confirmed in 2014/15 will form part of the service baselines from 1 April 2015 under the Better Care Fund
5. Note the interim governance arrangements for decision making within the context of the Local Development Fund and the future plans to establish a Section 75 Partnership Agreement for the Better Care Fund from 1 April 2015
6. Approve the milestones and develop the work-plan for the HWB and business review cycle accordingly, in particular noting the very challenging timescales for development of new areas of governance and care models by 30 June 2014
7. Receive a report in June 2014 outlining the arrangements for putting in place and administering robust criteria for joint commissioning and decommissioning
8. Note that a report on how the system captures learning from LLLB will be form part of the next update paper.

Board Priority(s) Addressed:

All

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Background documents (available for public inspection):

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

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

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
Local Development Fund 2014/15 and Better Care Fund 2015/16

Introduction

This paper summarises the work of the City Wide Leadership Group for the LLLB programme from December 2013 to February 2014, outlines the work plan for 2014/15 and the process for setting in place and managing a Local Development Fund. Specifically, the paper covers the following areas:

Section	Contents
1	Executive Summary • Programme achievements to date • Global investment synopsis (outline of services implemented and planned) • Headline Better Care Fund (BCF) - global resource and cost of investment plans, metrics • Local Development Fund (LDF) to support redesign and shift. • Governance
2	Locality Summaries • Progress against development of 'New Delivery Models' (NDMs) since December 2013. • Summary of the business cases underpinning investment in the NDMs 2014/15 (including wave one / pilots) • Locality governance
3	Better Care Fund • Resources for 2014/15 and 2015/16 across all partners. • Criteria to support investment. • Performance targets and metrics. • Governance – interim and future. • Investment proposals.
4	Forward plan • Development of additional NDMs and further investment proposals. • Indicative timelines
5	Recommendations

1. Executive Summary

1.1 This paper outlines the overall agreed proposal for the use of the Better Care Fund (BCF) for 2014/15. It has been agreed that additional investment of £5.1m from Manchester Clinical Commissioning Groups (CCGs) and £800k from Manchester City Council's Public Health resource will be added and this is the precursor to the establishment of a city-wide Local Development Fund (LDF).

1.2 The Executive Health and Wellbeing Group have recommended the setting up of the LDF with the aim of:

- Co-ordinating the commissioning of LLLB development across Manchester.
- Facilitating service and resource shifts through application of the LDF supported by evidence based joint commissioning.
- Ensuring recyclable investment – thus enabling scaling up of integrated out-of-hospital care and ensuring associated resource shifts for sustainability.
- Enabling innovation and testing out of new delivery models.
- Effectively moving money, resources and workforce round the system (supported by innovative arrangements such as Alliance Contracting).

1.3 An important target milestone of June 2014 has been agreed to have in place robust criteria for joint commissioning and decommissioning. To support this stretched performance targets are being developed. These phased targets are required to support the 20% shift from acute to out-of-hospital care over the next 5 years.

1.4 The report also contains the criteria for assessing the business cases for investment. The paper outlines processes for recommending £10.2m additional spend which will reduce the available total for investment in the following year. This has followed a detailed process of evaluating the business cases that have been put forward. It is recognised that it is critical that these decisions are very focused on the longer term aims and as such this criteria should be clearly evidenced before funding from the LDF is agreed and committed. There are inevitable transitional and double-running costs and work is underway to clarify those and their impact.

1.5 The three Manchester locality systems have each made excellent progress in the development of their new delivery models for:

- Adults at the end of life
- Adults with long term conditions
- Frail older adults and adults with dementia

It is proposed that the Manchester Local Development Fund/Better Care Fund will be utilised across the city to enable the implementation of these new delivery models during 2014/15. The LDF/BCF will comprise the following elements:

Manchester Local Development Fund / Better Care Fund Resources	**LDF 2014/15**	**BCF 2015/16**

Areas of investment	Source of funding	Lead	Total recurrent £'000	Total recurrent £'000
Carers break and reablement	Health	CCGs	5,000	5,000
Social care transfer	Health	MCC	9,998	9,998
Disabled Facilities Capital	Council	MCC	2,967	2,967
Social care capital	Council	MCC	1,485	1,485
Existing Integrated Care Models	Health	CCGs	5,100	5,100
Further investment in New Delivery Models	Health	CCGs	5,100	13,319
	Council	MCC	800	800
	Health	MCC	2,221	2,221
Care Bill implementation	Health	MCC	0	2,000
Total			**32,671**	**42,890**

1.6 The total resources available for 2014/15 are £32.7m. This is higher than the Initial amount of £26.8m owing to the allocation of £5.1m from the three Manchester CCGs (£1.7m per CCG) and £800,000 from MCC.

1.7 The timescale for developing business cases has been extremely short and partners across the health and care system have worked hard to ensure each business case was developed to the required timescale. Business cases were assessed against the set of criteria developed by the Citywide Leadership Group. Although these criteria do not explicitly describe the need for the evaluation of each business case; evaluation does form a key element of the CCGs' business case approvals process and so will be required.

1.8 Governance regarding decision making on investments utilising the CCGs' £5.1m have rested with each CCG. This has meant that final decisions on approved business cases have not yet been made but will be decided by each CCG during March 2014. Timescales for each CCG decision making process are as follows:

- Central Manchester CCG – Executive Management Team on 5th March 2014
- North Manchester CCG – Finance Committee on 24th March 2014
- South Manchester CCG – Finance Committee on 20th March 2014

1.9 The Executive Health and Wellbeing Group has supported the proposed measurement framework for the LLLB Programme. Based on this framework. Work is well underway to identify a small set of commonly agreed measures which can reported be reported to both Manchester City Council and the three Manchester CCGs (at citywide and CCG level) on a regular basis. Discussions are also taking place with the Utilisation Management Unit within the Greater Manchester Commissioning Support Unit (CSU) about the development of an 'analyser' tool to display and interrogate the data.

1.10 There is now a better understanding of the evaluation activities taking place in relation to the integrated care pilots within each of the three CCGs in the city and

what the common components of these are. As part of the implementation phase of the LLLB Programme learning will be captured in a more systematic way. The findings from the implementation of the New Delivery Models will be collated and shared across the health and social care system in Manchester and also across Greater Manchester and beyond. It is proposed that a further report on how the system captures its learning from the LLLB programme will form part of the next update paper to the Health and Wellbeing Board (HWB).

1.11 The Health and Wellbeing Board is asked to:

- Note the progress of the LLLB programme since December 2013, in terms of development of business cases to support investment in the priority new delivery models;
- Support the proposals for investment of £10.2m from the LDF/BCF for 2014/15 linked to financial plans;
- Note that further proposals for investment into the models to support the implementation of the Care Bill from April 2015 are required to be considered at the meeting of the Health and Wellbeing Board on 10th September.
- Note that investments confirmed in 2014/15 will form part of the service baselines from 1 April 2015 under the Better Care Fund;
- Note the interim governance arrangements for decision making within the context of the Local Development Fund and the future plans to establish a Section 75 Partnership Agreement for the Better Care Fund from 1 April 2015;
- Approve the milestones and develop the work-plan for the HWB and business review cycle accordingly, in particular noting the very challenging timescales for development of new areas of governance and care models by 30 June 2014;
- Receive a report in June 2014 outlining the arrangements for putting in place and administering robust criteria for joint commissioning and decommissioning.
- Note that a report on how the system captures learning from LLLB will be form part of the next update paper.

2. Locality Summaries

2.1 Central Manchester, Introduction

2.1.1 The Central Manchester system has been working towards integrated care since 2010. Our simple aim is that ***"no one should be in hospital who doesn't need to be in hospital".*** The Clinical Integrated Care Board has been the strategic forum where this vision has been shaped and oversight of implementation has taken place. The Living longer, living better (LLLB) programme has been an opportunity to work more effectively on a citywide basis, create a common offer for the people of Manchester and rise to the challenge of increasing scale and pace of developing out of hospital care. However, it is acknowledged that implementation is best undertaken within each of the three CCG areas within Manchester whilst ensuring effective connectivity and common offer to the city.

2.1.2 New Delivery Models

In Central Manchester a Provider Partnership Board, which reports to the CICB, has developed New Delivery Models (NDMs) for three of the five commissioner led care models for the priority population groups.

These are:

- Adults at the end of life
- Adults with long term conditions
- Frail older people and those with dementia.

These NDMs have been reported previously to the Executive Health and Wellbeing Group (EHWBG).

Membership of the provider partnership board represents:

Central Manchester Foundation Trust	**Manchester City Council**	**Manchester Mental Health and Social Care Trust**	**Central Manchester CCG**
Go to Doc	**North West Ambulance Service**	**Primary Care Manchester Ltd**	**Manchester Carers Forum**
Manchester Alliance for Community Care	**Health Watch**		

Alongside this the CCG has led the Primary care demonstrator programme following a successful bid for non recurrent funding from NHS England (Greater Manchester Area Team). Effective services are to be aligned with LLLB developments as part of the investment package to form a common out of hospital care programme.

One of the priority groups which didn't have a new delivery model developed for it (complex adults) has proposed investment.

2.1.3 Service Model and Shape

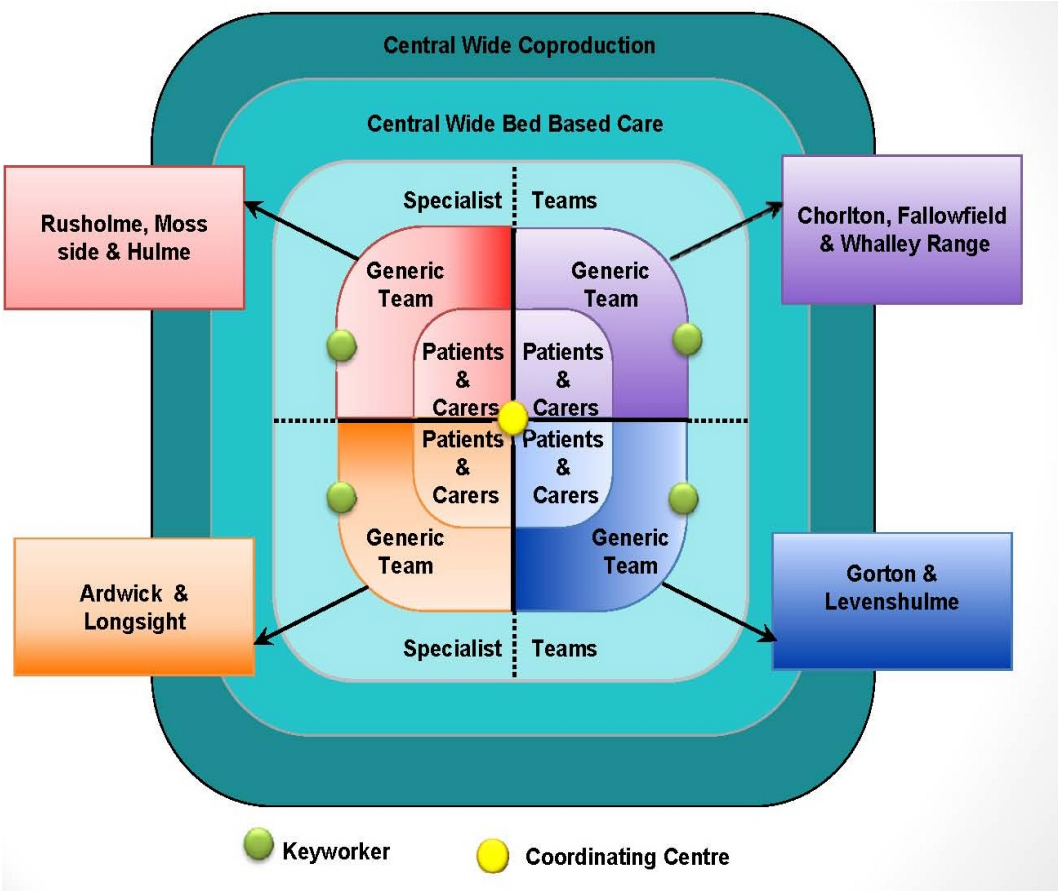
New Delivery Models Key Components
The NDMs for Central Manchester have five key components

- **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 (population circa 50,000 and 8-10 practices)** that can care for people within that area. The teams are known and consistent.
- **Specialist team from one hub,** where skills and capacity can be accessed if required by the locality team.

- **Carer Support** - A physical and virtual service giving advice and information through to carers (unpaid) and families.

2.1.4 This is illustrated in the figure below. The sections below describe how this will look in terms of new services developments. It is important to note there is no clear fit to population group and, therefore, implementation will work around the generic and specialist arrangements as one whole.

There is still some work to do in prioritisation so some aspects of this summary will not be implemented in the first phase on the basis of affordability.



2.1.5 End of Life Care

Investments will sustain funding for end of life care focussed upon residential care homes. Development of staff in the homes and additional district nursing support in the out of hours period has already made a significant impact upon people dying in their place of choice.

Prior to this work 45% of people died within their care home. In the first year of this service seventeen out of eighteen people's (94%) place of death was within the care home.

Further investments relate to the development of an online end of life care record shared across professional groups. This will be built upon the existing Integrated care record developed for Practice Integrated Care Teams.

Expansion of the Marie Currie supported discharge service at CMFT will bring capacity levels on a par with other parts of the city.

2.1.6 Frail Older People with Dementia/ Adults with Long Term Conditions

Given the level of overlap within these population groups and the service models developed for them these investments are described together.

They are described across two headings. Firstly, anticipatory care which focuses upon prevention of an urgent care need or reducing the acuity at which that need is met through earlier intervention. Secondly, response to an urgent care need with a more community based focus.

2.1.7 Anticipatory Care

Investment will sustain the Practice Integrated Care Teams (PICTs) which currently care for the people at highest risk of hospitalisation in Central Manchester. This follows a multidisciplinary team approach who identify people at high risk then care plan and case manage them in a tailored and intensive way. Currently Central's caseload is circa 400 and will rise to 800 by the summer. The two thousand people considered at highest risk of admission from which the PICT draw their caseload from consume £8m of non elective costs each year.

COPD teams, including specialist nursing and Active Case Managers, who link with general practice to care plan and offer response to exacerbation to COPD patients at high risk of admission. The service has been established for over a year in Gorton and Levenshulme and has recently been rolled out to all of Central Manchester. This service has started to work more closely with the PICTs supporting from a specialist perspective.

A locally commissioned service from primary care has proved successful in reducing admission rates relating to heart failure. This has focussed upon earlier identification and ensuring optimal management of people with LVSD (left ventricular systolic dysfunction). Optimal management includes adherence to NICE guidelines, care planning and monitoring, patient education supporting self management, access to specialist support and training. The locally commissioned service has only covered a small range of practices based upon clinical interest or capacity to deliver. The investment will ensure full population coverage.

Targeted GP led specialist nursing teams to support people in nursing/residential care homes. This service will build upon existing nursing teams by providing review and care planning, increased preventative interventions such as immunisations, a rapid assessment following a significant event e.g. admission, access to urgent medical assessment, in

hours support to carers. The service will establish links with hospital services e.g. the proposed proactive elderly care team to avoid admission or to facilitate effective discharge.

A locally commissioned service for primary care will resource practices to offer high quality dementia care focussing upon both medical and social aspects of care. National contracts support increased identification of dementia but have little emphasis on effective management. This investment will support evidenced based clinical management but also care planning and specifically support to carers.

2.1.8 Responsive Care

The Proactive Elderly Care Team would be based within the hospital focussing upon the early part of the acute non elective medical pathway. This team, including consultant geriatrician, psychiatrist and therapy support will work within A&E, Acute Medical Unit and the medical wards to give a comprehensive review to elderly patients, to care plan and manage their hospital attendance and effective shift into out of hospital care. This will incorporate some of the functions of the liaison in later years (LILY) pilot which will be discontinued in its current form at the end of March. The service will enable targeted input to support an effective and shortened acute episode and a transition into out of hospital care. The service can link to other developments such as the practice integrated care teams, care homes model, alternatives to transfer and ICAT to form a core of services around a vulnerable client group incorporating care in and out of hospital.

There are two service developments which link to Ambulance call out. These are being assessed to fit them into one service model. Alternatives to transfer is a partnership between NWAS and GoToDoc whereby ambulance crews can assess people who don't need to go to hospital but require an urgent assessment and management plan in order for them to be left safely at home. GoToDoc provide a GP face-to-face response within two hours of accepting the referral from NWAS. Ninety five percent of accepted referrals aren't subsequently transferred to hospital. Sustaining this investment will allow this to continue but also to develop the pathway to increase the level of referral made. The Intermediate Care Assessment team (ICAT) developed in a similar way receiving referrals from NWAS relating to people who had fallen to bring into the intermediate care service. This has since been expanded to increased clinical presentations and to take referrals from other professionals e.g. GP, district nurse and social worker. Development has also increased the hours of operation and shortened the response time to the referral.

To sustain the multidisciplinary health and care team who work to manage effective and prompt discharge of people requiring continuing healthcare packages. The service typically reduces average hospital stay for the client group by 7 days.

To support the recently established community service for intravenous (IV) therapies. This service promotes admission avoidance and early discharge for

people who need IV antibiotics or hydration. This will include pathways such as UTI, leg ulcers, chest infection etc. The service has already been shown to reduce admissions.

2.1.9 Complex Adults

Homeless people are higher users of urgent care. Typically attending A&E 6 times more often, admitted 4 times more often and when admitted stay 3 times longer. MPATH (Manchester pathway) is a shared investment with North Manchester which proactively reach in to hospital (Manchester Royal Infirmary) to manage patients and support their discharge into the community ensuring continued primary care engagement. The service has demonstrated reduction in attendance, admission and readmission rates during this period.

2.1.10 Primary Care Access

A key aspect of the primary care demonstrator programme. Funding will sustain these part way into the new financial year when NHS England funding ends. Access covers funding for practices to be responsive to urgent demand and committing to response rates to see patients with an urgent need. In addition it resources extended hours creating appointments at weekends and weekday evenings. Whilst not population group specific good primary care access is expected to support the priority population groups as they are high users of primary care.

2.1.11 Investment Planning

Approach

The Central system is working to a total investment of £3.4m. Of this sum £1.9m is committed to sustaining previous investments, or services already being implemented. The remaining £1.5m will be used to fund new developments through the prioritisation process.

All developments from the £3.4m will be subject to targets and performance management arrangements. Agreement around recurrence of investment will need to take place in light of the transition to the Better Care Fund in 2015/16 as well as the strength of evidence within business cases.

Prioritisation Process

The approach taken in the Central system has been to undertake the prioritisation process within the Provider partnership Board. In practice this has been an iterative process between provider partnership and the CCG.

The criteria which have been used to prioritise follow discussion at the CWLG. These are:

- Impact upon Better Care Fund indicators to align to the BCF fund and associated performance management.
- Impact upon 5 year aims for acute activity levels to align to sustainability of the system financially.

- Impact upon the agreed LLLB goals.
- Pace of implementation for maximum impact in the 14/15 period.

In addition there is a commitment to incorporate carer support into the business cases.

Prioritisation with providers is identifying areas of efficiency across service developments and opportunities to fit them more coherently together. This will increase value for money as well as a simplified system for patients and practitioners.

Governance Arrangements

Whilst the resource is held within the CCG's allocation it is subject to its scheme of delegation and, therefore, the formal decision making will be made by the CCG at its Executive Management Team meeting on 5th March 2014. However, the prioritisation process will be best undertaken by all the partners and operate in the spirit of future governance arrangements around the Better Care Fund. The CCG's decision making processes will provide assurance around strategic fit, the robustness of the cases, due process and affordability, but will not detract from the partnership decision making process.

This process has also taken in the views of the following groups:

- Central Manchester CCG patient and public advisory group
- Central Urgent Care Board
- Central Planned Care and Long Term Conditions Board
- Consideration within each partner organisation

2.1.12 Implementation

Provider Partnership
Implementation will be managed by the provider partnership, as will accountability for impact. An ongoing dialogue will be retained with commissioners via the Provider Partnership Board and the full system view via the CICB. Accountability to the commissioner will be through contracting arrangements (see 5.2).

Alliance Contract

It has been agreed that the majority of these investments will be developed into the pre-alliance contracting arrangements. Essentially, the investment will be made through a single contract between the commissioner(s) and the provider partnership. This will aid management of the resource as a whole and shared accountability through a single performance framework. It will also allow the new out of hospital care system to be implemented coherently and effective links to existing services to be made.

Performance Management and Learning

It has been agreed that the majority of these investments will be developed into the pre-alliance contracting arrangements. Essentially, the investment will be made through a single contract between the commissioner(s) and the provider partnership. This will aid management of the resource as a whole and shared accountability through a single performance framework. It will also allow the new out of hospital care system to be implemented coherently and effective links to existing services to be made.

2.2 North Manchester, Introduction

2.2.1 The North Manchester health and social care system has made excellent progress in delivering new models of integrated care in the last few years. Success stories include;

- The integrated health and social care hospital discharge team which has enabled substantial reductions in discharge delays and hospital lengths of stay
- North Manchester Integrated Neighbourhood Care with its model of integrated neighbourhood teams now rolled out across the CCG's practices to improve the care of patients identified as being at high and moderate risk of being admitted to hospital
- Crisis Response Service pilot (multi disciplinary service including nursing, therapy and social care) which is enabling patients to receive short term care in their own home rather than be admitted to hospital. We now plan to develop the service further as a key component of a new integrated intermediate care and reablement "intermediate tier" which is currently being designed which we envisage will go live during 2014-15.

The North Manchester system has recognised that developing integrated models of care offer the opportunity to reduce the need for our residents to be admitted to hospital. We also recognise that we need to invest in services outside hospital to enable this to happen. Our commitment to implement the LLLB new delivery models is demonstrated by our decisions regarding priorities for investment using the Better Care Fund.

2.2.2 New Delivery Models

North Manchester, local accountability and responsibility for LLLB is with the North Manchester Clinical Board. At its November 2013 meeting, the Clinical Board agreed which of the LLLB new delivery models would be its initial priority for development. As there was already considerable work underway in these areas, the following NDMs were prioritised:

- Adults at the end of life
- Adults with long term conditions
- Frail older people and those with dementia

Development of the NDMs was led by the North Manchester Provider Partnership.

2.2.3 Service Model and Shape

<u>End of Life Care</u>

The model for end of life care is based on the Midhurst MacMillan Community Specialist Palliative Care Service model. It covers all conditions, not just cancer. The model will develop a hub base to support four neighbourhood services. The hub will include:

- MDT leadership
- Coordination
- 24/7 helpline
- Support to the four neighbourhoods will include outreach, pharmacy advice, IV drugs and end of life hospice at home services

Adults with Long Term Conditions

The model recognises the broad spectrum of adults with long term conditions and that 70-80% of the cohort will be supported by self care and primary care. A smaller number with higher levels of need will need community based generalist and specialist support. A smaller number still will have the most complex needs and will have an integrated case managed approach.

The model is based on:

Prevention and Self Care Including:

- Patients and carers have access to information to self care, available through a range of media
- Access to lifestyle support services e.g. weight management, exercise, smoking cessation
- Assessment of social and psychological needs
- Community volunteer infrastructure

Coordinated Care Planning:

- Preventative/ self care planning
- Crisis/exacerbation planning
- Management/maintenance planning
- Community based services accessible to all

Access and Treatment:

- Consistent, high quality general practice
- Community based services, building on the North Manchester Integrated Neighbourhood Care Model utilising MDT planning and a keyworker approach
- Improved access to mental health and wellbeing services
- Specialist input to be community based (focused on our four neighbourhoods) where it is safe and cost effective to do so. This will build on the success of existing services such as community diabetes care
- Access to technology including assistive technology, telecare and telehealth
- Shared electronic care plan
- Rapid access to diagnostics
- Community Crisis Response Service

- Further development of our Ambulatory Emergency Care model which enables rapid access to specialist opinion, diagnostics and treatment without hospital admission
- Recognising the transition to end of life/frailty

Frail Older Adults and Adults with Dementia

The model is based on the key elements of prevention and self care; preventing hospital or long term care admission; minimising hospital stays, preparing for end of life.

Prevention and self care including:

- Patient and carer understanding of any long term conditions and the impact of any lifestyle choices
- Regular medication reviews
- Maximise take up immunisations and vaccinations and screening e.g. bone density
- Implementation of an agreed Frailty Tool and the development of an at risk register of frail older adults to enable proactive management
- Timely assessment for dementia, falls risk etc
- Proactive primary care management including a named GP for >75s
- Maximise use of technology including access to equipment and adaptations
- Agreed, shared care plan with an agreed coordinator of care
- Maximise opportunities to pursue leisure and learning activities e.g. Grand Day Out
- Professionals and carers trained to recognise deterioration

Preventing admission to hospital or long term care including:

- Named GP for >75s
- Improved access to general practice over the seven day week
- Ambulatory emergency care model that is fit for frail older adults
- Redesign of an integrated intermediate tier comprising intermediate care, reablement and crisis response
- Single point of access and coordination
- Care of the Elderly consultant outreach to community based services
- Rapid access to equipment and adaptations
- Rapid access to outpatient services

Making hospital stays as short as possible including:

- Development of an integrated frail older adult assessment and treatment centre
- Comprehensive geriatric assessment
- Care plan shared with hospital professionals and key worker advised of admission to support rapid discharge
- Timely discharge by effective communication with professionals and carers and rapid access to support including the intermediate tier
- Rigorous use of internal professional standards of all teams involved in inpatient care

- Minimising ward moves to prevent decompensation

Preparing for end of life

- Recognising the need to consider transition to palliative and end of life care

2.2.4 Investment Planning

Approach

The system in North Manchester is working to a total BCF investment of £3.4m; of this, £1.7m is committed to sustaining existing commitments for:

- North Manchester Integrated Neighbourhood Care, including its four neighbourhood teams
- Intermediate Care
- Crisis Response pilot

The remaining £1.7m in the proposed BCF budget has therefore been made available to support business cases that will contribute to the priority new delivery models. The production of these business cases was led by the CCG, with support from the relevant partner organisations that would be involved in the delivery of each case. The timescale for developing business cases and assessing them has been extremely tight which has been challenging for all involved.

All developments from the £3.4m will be subject to targets and performance management arrangements. Agreement around recurrence of investment will need to take place in light of the transition to the Better Care Fund in 2015/16.

Prioritisation Process

Although agreement regarding the prioritisation of new delivery models was made by the North Manchester Clinical Board and the North Manchester Provider Partnership has led the development of those new delivery models, in order to reflect the financial governance of the CCG, the prioritisation of the cases has been by the CCG's Finance Committee. Nine business cases were developed and reviewed by the Finance Committee on 17th February. Each business case was developed to meet the agreed criteria shown in Appendix 3b.

Governance Arrangements

As described above, as the £3.4m described above forms part of the CCG's allocation; the CCG has been responsible for the approval process however the CCG has worked with its partners to prioritise the use of the £3.4m of the Development/BCF to support the implementation of the new delivery models.. Partner organisations have been advised of the outcome of the meeting on 17th February and will continue to be engaged in further iterations of the prioritised business cases until the CCG formally approves expenditure in March.

Outcome

The Finance Committee considered nine business cases and assessed them against the agreed citywide criteria outlined in appendix 3b. Five business cases approved for further work to be undertaken, prior to a final decision being made by the Finance Committee on 26th March 2014:

- 10 additional intermediate care beds to enable additional capacity for more complex patients, ahead of a wider redesign of the whole intermediate tier including intermediate care beds and home care places, reablement and crisis response
- Mental health practitioners to enhance the capability and impact of the North Manchester Integrated Neighbourhood Care model integrated teams for patients with multiple long term problems
- Continue to fund the Manchester Pathway for homeless people pilot scheme in which the Urban Village Medical Practice provides in-reach care to homeless patients at the MRI and enables their registration with the practice (or other practices) for ongoing proactive primary care management. This case will form part of the forthcoming new delivery model for adults with complex needs. It was approved for further work at this stage owing to its state of readiness for implementation. This business case was developed jointly by the North and Central Manchester localities
- Community nutrition support to nursing homes
- Additional resources to social care to support the implementation of the frail older adults new delivery model including additional reablement capacity and assistive technology

Four other cases were considered by the committee but not approved for further work and submission to the approval meeting on 24th March 2014, however work on developing the cases will continue and will either be submitted for BCF in 2015/16 or will identify alternate sources of funding in 2014-15:

- Early supported discharge for stroke patients – this case requires resolution of tariff discussions relating to the whole pathway
- Primary care support to frail older adults – this case will be affected by other developments including the named GP for >75s and the new enhanced service for admission avoidance, full details of these proposals are not yet known so it was not felt possible to agree an additional scheme until this was known
- Care of the elderly consultant outreach to community services. Funding for the posts was within PAHT establishment and therefore did not require additional funding at this stage
- Implementation of the end of life care model. This model is supported by MacMillan for 14/15 and therefore BCF would not be needed for implementation in 14/15

Implementation

Following final decision making on 24th March 2014, approved business cases will be implemented immediately. Any cases requiring recruitment will have a

lead in time but this will occur before the agreed 30th June implementation deadline. All approved business cases will have rigorous monitoring and evaluation processes to ensure we can measure the impact of the BCF investment. Locally, implementation, monitoring and evaluation will be the responsibility of the North Manchester Clinical Board.

Although there are no immediate plans to develop an Alliance or pre-Alliance contract as is being developed in Central Manchester, it is envisaged that the principles of Alliance contracting will be adopted in North Manchester. Where appropriate new commissioning and contracting models will be explored and it is envisaged that the new intermediate tier model will include a joint commissioning model between MCC and NMCCG.

2.3 South Manchester, Introduction

The primary focus of our work since December 2013 has been in the development of our New Delivery Models (NDM). We believe our NDM will be delivered through enhancing the existing Neighbourhood Teams (NT). As previously reported, through the collaboration of commissioner and provider partners in South Manchester we have agreed the core elements of the NDM that would be required to enhance the existing NT.

2.3.1 New Delivery Models

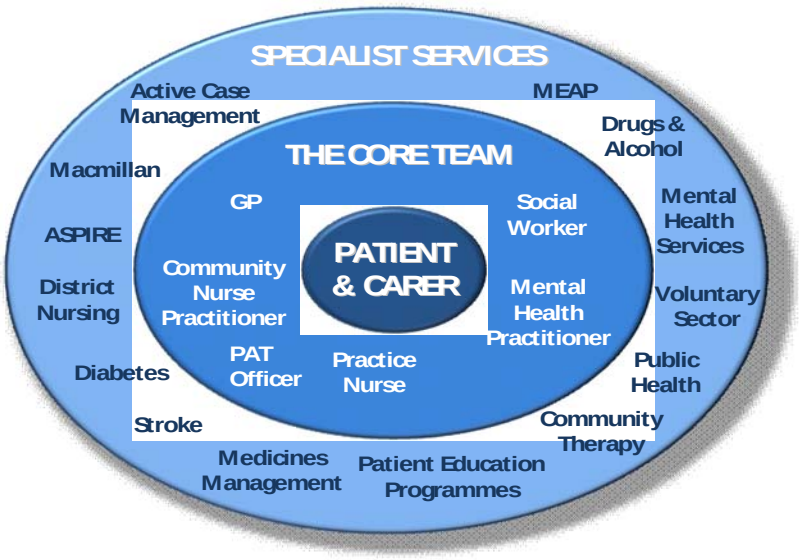
The South Manchester System is committed to implementing the LLLB new delivery models and this is demonstrated by our decisions regarding priorities for investment using the Better Care Fund.

The South Manchester Integrated Care Board held on the 15 October 2013 agreed that our system would prioritise the following population groups during 2014/15:

- Frail older people and those with dementia
- Adults at the end of life
- Adults with long term conditions

The South Manchester Provider partnership have led the development of the NDM

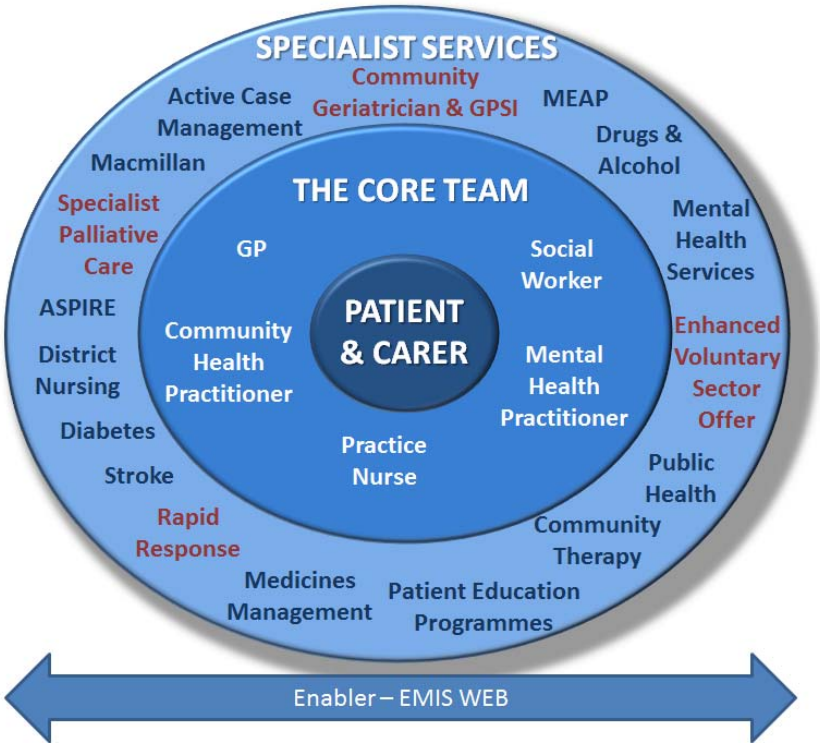
2.3.2 South Manchester CCG Neighbourhood Team



Since June - December 2013 the NT have supported 499 patients the impact is showing positive results in that there has been a:

Reduction of 34% in A+E attendances
Reduction of 24% in non elective admissions
Increase of 20% in length of stay
Reduction of 6 % in outpatient appointments

2.3.4 <u>Enhanced Neighbourhood Team</u>



We strongly believe by enhancing the NT with additional skills, knowledge and expertise will provide coordinated and responsive community based care that will build on the results outlined above

2.3.5 Business cases underpinning investment in the NDMs 2014/15

Our Approach

The system in South Manchester is working to a total BCF investment of £3.4m; of this, £1.7m is committed to sustaining existing commitments for:

- South Manchester Neighbourhood Teams – providing full population coverage

The remaining £1.7m in the proposed BCF budget has therefore been made available to support the business case for enhancing the NTs that will contribute to the priority new delivery models. The production of this business case was led by the CCG, with support from the relevant partner organisations that would be involved in the delivery of the enhanced elements of the NTs

All developments from the £3.4m will be subject to targets and performance management arrangements. Agreement around recurrence of investment will need to take place in light of the transition to the Better Care Fund in 2015/16.

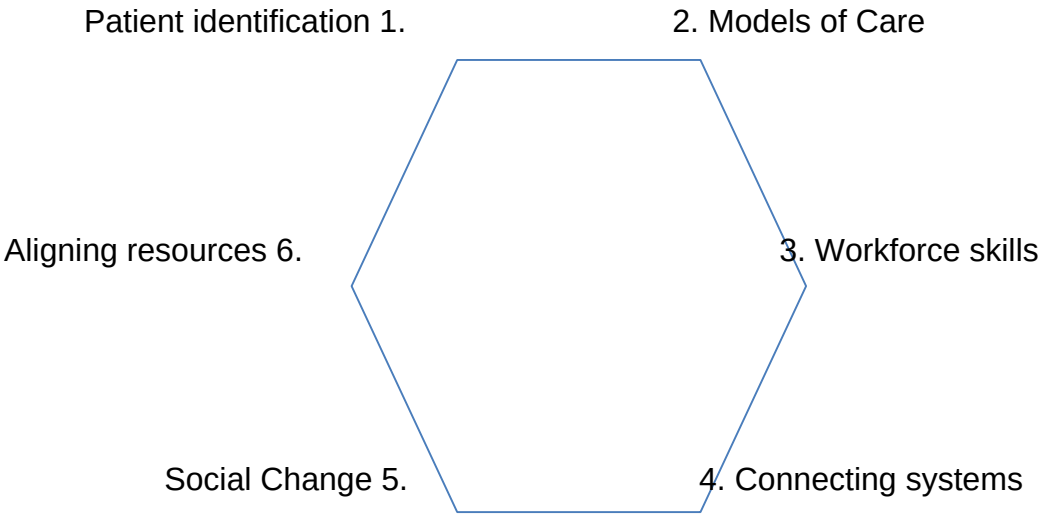
2.3.6 Enhancements to the Neighborhood Teams across the 4 GP patches

The enhanced elements of the ENT will see:

- Named geriatricians, and GPSi for each GP patch providing community based medical cover to support people to live independently and provide a rapid response to prevent a hospital admission. This medical cover will be provided to our Frail older adults/Adults with Dementia and adults at the end of their life regardless of where they reside (in their own home, care or nursing home)
- The introduction of a rapid response element to the ENT that will be managing people in the community who become unwell providing a virtual ward concept with rapid response of 1 hour for a short period of time (c72 hours) to enable the ENT to pick up care after this period.
- Specialist Palliative Care Community support providing multidisciplinary specialist palliative care including:
    - Diagnostics
    - Symptom Control
    - Prescribing
    - Advice and support
    - Additional support including OT and physio and specialist social worker
- Using the existing MCC framework of home care services for South Manchester, we will commission additional sitting service provision in South Manchester to support frail older people during the last days of their life in their own home.
- The introduction of frailty assessment that can be carried out by families, carers and practitioners supporting the early identification of frailty. The implementation of a frailty tool will see throughout 2014/15 the completion of 7,500 frailty assessments.
- Improved Communication and enhanced IM&T to ensure an integrated approach across secondary, primary care and social care supporting shared care planning- community based staff will have access to mobile solutions and EMIS web GP clinical systems.
- The implementation of an OD plan specifically aimed at supporting the workforce, patients, carers and families in the implementation of the NDM, we are calling this

“Our Community of Connected Individuals”

Our community of connected individuals will be supported to deliver community based care through a range of approaches to learning, sharing best practice and education.



Prioritisation Process

The criteria which have been used to priorities follow discussion at the CWLG. These are:

- Impact upon Better Care Fund indicators to align to the BCF fund and associated performance management.
- Impact upon 5 year aims for acute activity levels to align to sustainability of the system financially
- Impact upon the agreed LLLB goals.

Governance

Investments will be approved by the CCG's finance committee at its meeting on 20th March 2014. This will be by recommendation by the senior management Team. They will also progress through a parallel process through the SICB, Executive Health and Wellbeing Group and to the Health and Wellbeing Board.

The table below shows the key elements of the Enhanced NT teams that have been developed into a single business case

Ref	*New Delivery Models: Frail Older Adults*	*SMCCG Lead*	*UHSM Lead*	*MCC Lead*	*Finance*
1	**Frailty Tool**	JM	IL	DE	JP
2	**Neighbourhood Team - Enhancement** • Rapid Response • Community Hospital (Intermediate care/respite beds) • Community Geriatrician/GPSi • Single point of access • Community surveillance: Service for older people (3rd Sector support)	 TE TE TE JM	 KC AH AH AH	 DE/DW DE/DW	JP/MR
3	**Communication** • EMIS Rollout for community services • Mobile solutions for staff • MiCare	PW	PC	NW	JP/MR
4	**Organisation Development**	CE	IL/KC	DE	

3. Better Care Fund

3.1 Resources

The following resources have been confirmed for the Local Development Fund and Better Care Fund in 2014/15 and 2015/16, respectively:

Ref	*New Delivery Models: End of Life*	*SMCCG Lead*	*UHSM Lead*	*MCC Lead*	*Finance*
1	**Neighbourhood Team - Enhancement** • Sitting Service • Speciality palliative care (consultant, nursing, physio, OT) • Bereavement support -counselling and listening services	 JM JM JM	 KC AH AH	 DE/DW	JP/MR

Manchester Local Development Fund / Better Care Fund Resources			**LDF 2014/15**	**BCF 2015/16**
Areas of investment	**Source of funding**	**Lead**	**Total recurrent £'000**	**Total recurrent £'000**
Carers break and reablement	Health	CCGs	5,000	5,000
Social care transfer	Health	MCC	9,998	9,998
Disabled Facilities Capital	Council	MCC	2,967	2,967
Social care capital	Council	MCC	1,485	1,485
Existing Integrated Care Models	Health	CCGs	5,100	5,100
Further investment in New Delivery Models	Health	CCGs	5,100	13,319
	Council	MCC	800	800
	Health	MCC	2,221	2,221
Care Bill implementation	Health	MCC	0	2,000
Total			**32,671**	**42,890**

Appendix 3/A provides more detail about the change in contributions in each financial year, together with some supporting commentary. The value of the Local Development Fund is now £32.7m (previously £26.8m). The changes relate to:

- £5.1m confirmed additional CCG resource across the three Manchester CCGs (£1.7m per CCG, for which business cases and expenditure plans have been developed).
- £800k additional Public Health resource, this may rise to £2.1m, subject to other risks being managed.

3.2 The Local Development Fund for 2014/15 will 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 integrated care schemes in Central, North and South Manchester
- The funding of part of the 'alliance contracts', linked to achievement of agreed performance metrics.

LLLB 'Programme Management Office' contributions are not captured in the above table as decisions are awaited from partner organisations to continue to support the recently proposed governance structures for 2014/15. When fully approved, this would increase the resource by £50k per partner (offset by planned commitments).

The LLLB programme sits within the wider reforms affecting the Manchester Health Economy. The achievement of the stretch targets will contribute to the

significant gap caused by spending reductions and demographic pressures across the city. LLLB is working closely with the Healthier Together programme and the review of Primary Care to try to address this gap.

3.3 Criteria to Access Funding

The Executive Health & Wellbeing Group received a set of criteria recommended by the City Wide Leadership Group (CWLG) for the assessment of all business cases being developed for the use of 2014/15 Local Development Fund resources. These are included in Appendix 3/B.

The prioritisation framework establishes a common set of criteria to be used as part of the approval process for business cases relating to the LDF. These criteria have been used in the interim to enable projects to be developed, whilst governance arrangements for the pooled BCF are developed for 2015/16.

The criteria have been established to support transparency in decision making and to provide a degree of consistency for all stakeholders involved in preparing and evaluating business cases under the LDF, given that many different governance arrangements are currently in place across the city. The criteria are based upon a range of factors, including:

- Financial affordability and value for money considerations.
- Activity change targets established by stakeholder Directors of Finance (which are linked to the key drivers for change under the 'Healthier Together' programme
- Contribution to achieving stretch targets to make progress towards the performance of the ten most deprived cities or England average
- Performance measures developed for the LLLB programme.
- National conditions set by the Department of Health for the Better Care Fund.

The criteria have been designed to support the internal governance processes of partners by adding a layer of consistency around the overall recommendations for use of the LDF funds.

The full governance arrangements supporting future developments for the formal pooled budget will need to be developed over quarter one of 2014/15 to support delivery of future work against the proposed timeline described in more detail below.

3.4 Performance Metrics and Payment

The Better Care Fund metrics and locally agreed targets at the point of the draft submission to NHS England on 14 February 2014, are included in Appendix 3/C. In summary, the metrics are:

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population (6 month average)
- Avoidable emergency admissions per 100,000 population - composite measure (6 month average)
- Patient / service user experience - National metric (under development) is to be used
- Estimated diagnosis rate for people with dementia

The targets for all of the metrics with the exception of the first (permanent admissions of older people to residential and nursing care homes) have been set to match the minimum level of performance required to achieve a statistically significant level of change, in the context of expected population change.

NHS England will review the Better Care Fund submission to ensure that the scale of ambition within the plan is sufficient, performance targets are statistically significant and that the applications have a robust contingency plan in case targets are not achieved. NHS England will then feed back any changes that need to be incorporated into the final submission due by the 4th April 2014.

The agreed targets will be calculated at CCG area level to be delivered to support the ambition for the models being developed and will reflect minimum required improvement in performance. Stretch targets will also provided for 2014/15 to make progress towards the performance of the 10 most deprived cities (or England average) over the next five years.

Investment must be focused upon the contribution of the new care models towards the activity stretch targets, as unless these are achieved there will remain significant financial pressures across the health and social care economy.

The Government has indicated that the Performance Related Pay (PbR) element of the BCF will not be withheld if targets are not achieved, which in Manchester element is expected to be circa £11m. There will however be continued scrutiny by NHS England and the Department of Health of how the fund is being used to drive performance.

3.5 Summary of Investment Proposals for the New Delivery Models

Of the total £32.7m within the scope of the Local Development Fund in 2014/15, £13.2m is currently available for investment in the LLLB delivery models across the city, either through continuation of existing integration schemes (£5.1m) or development of new services (£8.1m). In summary, partners' contributions are:

Areas of investment	Source of funding	Lead	Total resource £'000		
			2014/15	Change 2015/16	Total 2015/16
Existing Integrated Care Models	North CCG	CCGs/ MCC	1,700	0	1,700
	Central CCG		1,700	0	1,700
	South CCG		1,700	0	1,700
Further investment in New Delivery Models to include implementation of Care Bill[2]	North CCG	CCGs/ MCC	1,700	4,176	5,876
	Central CCG		1,700	3,521	5,221
	South CCG		1,700	2,522	4,222
	Council		800[1]	0	800
	Health		2,221	0	2,221
Total			**13,221**	**10,219**	**23,440**

[1]As stated in the resources section above, the Public Health contribution may increase by £1.3m, subject to other risks being managed. This may further increase the amount of funding for investment in new models in 2014/15.
[2] The revenue implications of the Care Bill are an estimate. Changes in assumptions will alter the level of resource available for investment in the new models in 2015/16.

The proposed use of these funds by locality are shown in Appendix 3/E. In developing integrated models CCGs and the Council have planned to utilise the 2014/15 contributions (i.e. no more than £3.4m in 2014/15) phasing developments between 2014/15 and 2015/16 according to prioritisation processes.

The Council's duties under the Care Bill from April 2015 are set out below. The estimated cost of this for integrated care models is £2m based on a local proportion of the indicative cost nationally by Government. Regionally through the Association of Directors of Adult Social Service (ADASS) and in conjunction with Department of Health, Local Authorities are seeking to identify the target population group the new duties will be most pertinent to. It is expected that there will be a significant overlap with the priority cohorts for LLLB. In order to ensure that the Better Care Fund supports protection of social care and to tackle the significant financial challenge for the health and social care economy over the next five years, the new duties under the Care Bill must be addressed through integrated community based health and care services. The next wave of business cases for development of the models for HWBB in September must address the duties under the Care Bill to be in place for April 2015. By this stage it is expected that we will have greater clarity on respect of these responsibilities.

3.5.1 Care Bill - by April 2015 the Local Authority will:

- Provide universal services intended to prevent, reduce or delay needs and information, advice and guidance.

- Enable direct access to universal services, with some exceptions where assessment maybe needed to determine suitability.
- Ensure people with needs that can be met through universal services are directed appropriately to universal services with information on how to access.
- For those whose need cannot be met through universal services, carry out an individual assessment or carer assessment for those that appear to have needs for care and support. This must consider benefit from universal or local services as part of assessment
- For a person that meets eligibility criteria, determine if the individual requires LA support, what support would be appropriate.
- For those that do not want LA support, provide information and advice on how to meet needs and how to prevent or delay future needs
- For those that do want LA support, help the person determine how needs are to be met through a Care and Support Plan:
    - Ensure the care and support plan describes what needs the person has and which needs the LA will meet.
    - Agree with the person how needs are to be met and what type of care and support they want.
    - Put care and support in place to meet the person's needs.
    - Set up a Personal Budget

  Review the Care and Support Plan to ensure needs continue to be met to include a review of the value of the personal budget.

  The implementation of the Care Bill will provide a more thorough process to enhance safeguarding of vulnerable adults and their carers. It will also increase significantly the number of people requiring an assessment and the availability of the services for them such as more support for carers. The detail of what is expected is yet to be finalised but it is clear that these are significant additional responsibilities that the Local Authority is expected to implement.

  The Better Care Fund also has the responsibility to protect Social Care as a national condition. This is against a backdrop of increasing need and cost brought about by an ageing population and the rise in early onset conditions as well as inflation increasing costs. These pressures are expected to be met through the Better Care Fund and need to be integral to all the work in the NDMs.

3.6 Current and Future Governance Arrangements – Section 75 Partnership Agreement

To support the governance and operation of the Better Care Fund, a formal Partnership Agreement is required between the commissioning partners in Manchester. This will take a significant level of effort to finalise, not least because of the need to:

- Agree the scope of the pool in terms of partner contributions from the Better Care Fund and from other existing funding/budgets:
- Engage and consult upon proposals

- Propose risk management arrangements for the use of the pool (including, for example, the level of contingencies and other risk sharing that may be required);
- Identify the processes to be adopted by all partners in the use of the BCF for short, medium and longer term system change;
- Obtain legal advice for all partners; and
- Formalise through internal governance processes in advance of formal sign off.

The 2014/15 planning cycle will require a number of formal communications to providers by 30 September 2014. This will necessarily drive the timeline (see Section 4) for production of the underpinning governance framework, as well as future cases for change. For this reason, a draft Partnership Agreement will need to be in place by 30 June 2014 to enable consultation on some outline principles and in particular, policies, processes and format for agreement of future levels of expenditure within the scope of the BCF.

4. Forward Plan

4.1 Timeline for Further Development of the Better Care Fund

The proposed timeline for the development of the Better Care Fund over the course of 2014/15 is included in Appendix 4/A.

The key areas to be developed over the coming six months are:

By	Milestones
31 March 2014	• HWB approval of plans for use of Better Care Fund/Local Development Fund in 2014/15
31 May 2014	• New care models defined for the two remaining priority groups (Complex Adults, Children with Long Term Condition) • Updated criteria and governance arrangements for submission and consideration of future business cases to be confirmed and agreed
30 June 2014	• Draft Section 75 Partnership Agreement prepared including proposals for risk management across the city • Outline business cases developed for the next wave of investment in the new care models within each locality • HWB review outline cases for the next wave of investment • Agreement of operation of Local Development Fund including robust evaluation and decommissioning decision making.
31 July 2014	• Full business cases developed for investment • Locality evaluation report from first wave of investment to HWBB to support decisions about continuation of, or exit from, integration services in 2015/16
10 September 2014	• HWB consider evaluation reports summarising Cost Benefit Analysis of first wave schemes and determine continuation or exit

By	Milestones
	• HWB review full business case proposals and approve wave two investment • Outline expenditure plans updated for approvals
30 September 2014	• Commissioning intentions confirmed to providers (continuation and / or notices for wave one, plus proposals for wave two investment) • Changes in future commissioning arrangements formally notified to providers (Manchester City Council host for pooled budget) • Outline expenditure plans revised for the Better Care Fund

5. Recommendations

5.1 The Health and Wellbeing Board is asked to:

- Note the progress of the LLLB programme since December 2013, in terms of development of business cases to support investment in the priority new delivery models;
- Support the proposals for investment of £10.2m from the LDF/BCF for 2014/15 linked to financial plans;
- Note that further proposals for investment into the models to support the implementation of the Care Bill from April 2015 are required to be considered at the meeting of the Health and wellbeing Board on 10th September.
- Note that investments confirmed in 2014/15 will form part of the service baselines from 1 April 2015 under the Better Care Fund;
- Note the interim governance arrangements for decision making within the context of the Local Development Fund and the future plans to establish a Section 75 Partnership Agreement for the Better Care Fund from 1 April 2015;
- Approve the milestones and develop the work-plan for the HWB and business review cycle accordingly, in particular noting the very challenging timescales for development of new areas of governance and care models by 30 June 2014;
- Note that a report on how the system captures learning from LLLB will be form part of the next update paper.

Appendix 3/A – Local Development Fund and Better Care Fund Resources

Local Development Fund / Better Care Fund Resources			2014/15 (Base)	2014/15 (New)		2015/16	
Areas of investment	**Source**	**Lead**	**Recurrent**	**Additional**	**Total recurrent**	**Additional**	**Total recurrent**
			£'000s	**£'000s**	**£'000s**	**£'000s**	**£'000s**
Carers break and reablement	Health	CCGs	5,000	0	5,000	0	5,000
Social care transfer	Health	MCC	9,998	0	9,998		9,998
Disabled Facilities Capital	Council	MCC	2,967	0	2,967	0	2,967
Social care capital	Council	MCC	1,485	0	1,485	0	1,485
Existing Integrated Care Models	Health	CCGs / Providers/ MCC	5,100	0	5,100	0	5,100
New Delivery Models to include Care Bill implementation[2]	Health	MCC	0	2,221	2,221	0	2,221
	Council	MCC		800	800	0	800
	Health	CCGs		5,100	5,100	10,219	13,319
Total			**24,550**	**8,621**	**32,671**	**10,219**	**42,890**

[1] A Public Health contribution of between £1.3m £2.6m has been identified for 2014/15, however, this is subject to final mitigation of other pressures. Therefore, for the purposes of the summary, the minimum resource has been assumed at this point as available for implementation of new delivery models.

[2] The revenue implementation costs associated with the Care Bill have been notified as part of the national conditions of the Better Care Fund by NHS England and the Local Government Association. The £2m estimate is a broad assumption at this point about the costs in Manchester of the Care Bill. Cost estimates will be refreshed as more information becomes available.

Appendix 3/B – Interim Business Case Prioritisation Framework / Criteria

No	Criteria	Rationale	Supporting Detail	Comments
1	The business case is affordable both now and in the future (if recurrent) and represents value for money for the health economy.	Cases that are not affordable (cost more than current services) or do not represent good value for money will not be approved as the BCF has a finite resource that must be used to have the greatest benefit.	Commissioners' business case approval processes will need to ensure that due rigour is applied in evaluating assumptions, validating evidence and financial modelling in order to form a conclusion about whether each case is financially viable. Similarly, providers' financial evaluation processes will need to ensure that proposed business models are sound and do not create undue financial risks to their organisations. Due to the various investment policies currently operating within Manchester, specific financial assessment templates etc are not explicitly included in this framework. However, the H&WBB will seek assurances from the CCGs in the following areas: • Affordability against resources • Value for money (costs of the case set against expected efficiencies) • Investment appraisal (payback period, including expenditure and savings profile) • Transitional costs • Exit strategy and associated costs	This criterion will override all other business case approval criteria.
2	The business case clearly addresses the performance related pay metrics for the Better Care Fund.	Cases should be delivering against the Better Care Fund metrics to ensure that Manchester does not lose up to £11m of funding from	The payment related metrics for the BCF are 1 to 4 only: 1. **Permanent admissions** of **older people** (aged 65 and over) to residential and nursing care **homes** per 100,000 population 2. **Proportion of older people** (aged 65 and over) who were **still at home 91 days after discharge** from hospital into reablement / rehabilitation services 3. **Delayed transfers of care** from hospital per 100,000 population 4. **Avoidable emergency admissions** (composite measure) 5. Patient/service user experience (to be defined)	Business cases that target more than one of the metrics will be prioritised above those which only seek to address one of the metrics.

<table>
<tr><td></td><td></td><td>2015/16.</td><td>6. Diagnosis for dementia</td><td></td></tr>
<tr><td>3</td><td>The business case targets the LLLB priority population groups</td><td>Prioritised population groups are considered to be the largest consumers of resources and therefore work in these areas will have the biggest opportunities for efficiencies and improving quality.</td><td><table>
<tr><th></th><th>Sub-group name</th></tr>
<tr><td>1</td><td>End of life care - Adults and children</td></tr>
<tr><td>2</td><td>Long term conditions - Adults</td></tr>
<tr><td>3</td><td>Frailty / dementia - older people</td></tr>
<tr><td>4</td><td>Complex needs - Adults</td></tr>
<tr><td>5</td><td>Long-term conditions - Children</td></tr>
<tr><td>6</td><td>Carers - Adults and children</td></tr>
<tr><td>7</td><td>Good health - older people</td></tr>
<tr><td>8</td><td>Early years (0-4)</td></tr>
<tr><td>8b</td><td>Maternity</td></tr>
<tr><td>9</td><td>Good health - children</td></tr>
<tr><td>10</td><td>Staff - Adults</td></tr>
<tr><td>11</td><td>Good health - Adults</td></tr>
</table></td><td>Groups 1 to 3 prioritised during 2013/14 and 2014/15.

Groups 4 and 5 for development from 2015/16.

Investment case for Early Years NDM is being produced in parallel to this process</td></tr>
<tr><td>4</td><td>Service can go live on or close to 1 April 2014 (no later than 30 June 2014).</td><td>Services that start as soon as possible will have the greatest opportunity of changing outcomes for the identified population groups and support achievement of</td><td>Services must start between 1 April 2014 and 30 June 2014.</td><td>Services that can be implemented earliest will be prioritised over others (in combination with judgement about other deliverables and business case criteria).</td></tr>
</table>

<table>
<tr><td></td><td></td><td>BCF performance related pay.</td><td></td><td></td></tr>
<tr><td>5</td><td>Business case supports hospital activity shift targets as agreed by Directors of Finance for Healthier Together.</td><td>The Healthier Together programme is reliant upon delivery of effective integrated services within the community.</td><td>The five year activity reduction targets are:
<table>
<tr><th colspan="3"></th><th colspan="5">STRATEGIC TARGETS
Manchester CCGs (Gross % shift based on 2013/14 M8 Forecast SLAM outturn)</th></tr>
<tr><th colspan="3"></th><th colspan="5">TARGET REDUCTIONS - 5 YEAR PERIOD</th></tr>
<tr><th rowspan="2">POD</th><th rowspan="2">Agreed target shift %*</th><th>Indicative average prices</th><th>Target shift required 2014/15 to 2018/19</th><th>Indicative tariff cost of activity shift</th><th>North (All Trusts)</th><th>Central (All Trusts)</th><th>South (All Trusts)</th></tr>
<tr><th>£</th><th>Activity</th><th>Indicative cost £</th><th>Activity</th><th>Activity</th><th>Activity</th></tr>
<tr><td>A & E</td><td>-10.0</td><td>£97</td><td>26,998</td><td>£2,606,679</td><td>8,927</td><td>11,415</td><td>6,655</td></tr>
<tr><td>EL</td><td>-8.0</td><td>£1,043</td><td>4,001</td><td>£4,172,506</td><td>1,501</td><td>1,243</td><td>1,257</td></tr>
<tr><td>NEL</td><td>-20.0</td><td>£1,733</td><td>11,098</td><td>£19,231,730</td><td>4,228</td><td>3,546</td><td>3,325</td></tr>
<tr><td>OP</td><td>-16.0</td><td>£101</td><td>78,998</td><td>£7,964,718</td><td>25,481</td><td>25,957</td><td>27,560</td></tr>
<tr><td colspan="3">TOTAL - ALL CCGs</td><td>121,095</td><td>£33,975,633</td><td>40,137</td><td>42,161</td><td>38,797</td></tr>
</table></td><td>The targets agreed by partner Directors of Finance in January 2014 will be applied to 2013/14 forecast outturn CCG activity at 30 November 2013, before any effects of population change (therefore, the actual activity baseline in 2018/19 may still be higher than 2013/14 but mitigated due to the effect of planned service change).</td></tr>
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The targets are based on review of NHS Comparators information for NHS Manchester in 2012/13:

<table>
<tr><th>POD</th><th>Shift to England average</th><th>Shift to NW SHA average</th><th>Agreed target shift %</th></tr>
<tr><td>A & E</td><td>22%</td><td>-2%</td><td>-10.0</td></tr>
<tr><td>EL</td><td>9%</td><td>15%</td><td>-8.0</td></tr>
<tr><td>NEL</td><td>35%</td><td>20%</td><td>-20.0</td></tr>
<tr><td>OP</td><td>17%</td><td>15%</td><td>-16.0</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Partnership approach is reflected in the service delivery model.</td>
<td>LLLB is about integration. This means working with a range of stakeholders to commission and deliver quality services in Manchester. Partnerships are a key enabler in this respect.</td>
<td>Partnerships within Manchester’s stakeholder groups, including:
1. CMFT
2. UHSM
3. PAHT
4. MMHSCT
5. MCC
6. Central Manchester GP Provider Organisation
7. South Manchester GP Federation
8. North Manchester GPs
9. Manchester Carers Forum
10. Manchester Health Watch
11. Go To Doc – Out of Hours provider
12. MACC
13. North West Ambulance Service</td>
<td>Partners identified in the BCF business case for the H&WBB. There may be other partners not listed here.</td>
</tr>
</table>

7	Business case supports delivery of the broader metrics within the agreed LLLB programme performance framework	The programme's performance framework sets the aspirations and context within which service and quality improvements are required for the health and social care of Manchester's population. Cases that contribute to these aspirations will be goal congruent with the strategy.	LLLB metrics not already specified in the criteria are: 1. Healthy life expectancy at birth (PHOF 01i) 2. Potential years of life lost (PYLL) from causes considered amenable to healthcare (NHSOF 1a) 3. % children achieving a good level of development at the end of reception based on EYFSP assessment 4. % of Year 1 pupils achieving the expected level in the phonics screening check 5. % of people who use services who have control over their daily life (ASCOF 1B) 6. % of people helped to live independently 7. Ambulance services (% of emergency patient journeys to destinations other than Type 1 & 2 A&E) 8. Primary care (Measure to be agreed) 9. % of adult service-users supported to live at home in receipt of a community based service 10. Proportion of deaths at home/in place of choice 11. % recommending the NHS service they have received to friends and family who need similar treatment or care ('Friends and family test') 12. Patient experience of GP services (NHSOF 4a.i) 13. Patient experience of GP out of hours services (NHSOF 4a.ii) 14. Patient experience of community health services (Measure to be agreed) 15. Overall satisfaction of people who use services with their care and support (ASCOF) 16. Overall satisfaction of carers with social services (ASCOF)

8	Meets national conditions for the Better Care Fund	Requirements of the Better Care Fund and supports delivery of strategic ambition for LLLB programme	**1. Protecting social care services** The implementation of the Care Bill will provide a more thorough process to enhance safeguarding of vulnerable adults and their carers. It will also increase significantly the number of people requiring an assessment and the availability of the services for them such as more support for carers. The detail of what is expected is yet to be finalised but it is clear that these are significant additional responsibilities that are expected to be implemented. In addition the Better Care Fund also has the responsibility to protect Social Care, ensuring that customers continue to receive services against a backdrop of increasing need and cost brought about by an ageing population and the rise in early onset conditions as well as inflation increasing costs. These pressures need to be integral to all the work in the NDMs. **2. 7 Day Services to support discharge** Set out how/if the business case support implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends. **3. Data Sharing** Ensure proposals support continuation or improvement of data sharing arrangements **4. Joint assessment and accountable lead professional** Ensure proposals set out the agreed accountable lead professional and a joint approach to assessing risk, planned care and allocating a lead professional where appropriate.

Appendix 3/C – Better Care Fund Performance Metrics

These will need to be translated into stretch targets. This work is on-going.

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*	825.9	N/A	800.0
	Numerator	400		398
	Denominator	48,430		49,706
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	63.4	N/A	64.4
	Numerator	295		319
	Denominator	465		495
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (6 month average)	*Metric Value*	217.2	208.9	200.5
	Numerator	869	839	810
	Denominator	400,003	401,812	403,904
		(June 2013 - Nov 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions per 100,000 population - composite measure (6 month average)	*Metric Value*	219.2	211.8	204.3
	Numerator	1,120	1,089	1,058
	Denominator	510,993	514,513	517,804
		(April 2013 - Sept 2013)	(April - September 2014)	(October 2014 - March 2015)

Patient / service user experience - National metric (under development) is to be used	N/A	N/A *(insert time period)*	N/A	N/A *(insert time period)*
Estimated diagnosis rate for people with dementia	*Metric Value*	60.8	61.8	62.7
	Numerator	2,207	2,276	2,344
	Denominator	3,630	3,684	3,741
		(2013)	(2014)	(2015)

Appendix 3/E – Proposals for use of the Local Development Fund and Better Care Fund

Manchester Local Development Fund / Better Care Fund Commitments			LDF 2014/15			BCF 2015/16	
Comm-issioner	**Scheme**	**Provider(s)**	**Existing £'000**	**New £'000**	**Total £'000**	**New £'000**	**Total £'000**
North Manchester CCG	• NMINC • Crisis Response	PAHT, MMHSCT, MCC, Primary Care	2,216		**2,216**		**2,216**
	• NMINC extension - MH practitioners • MPATH (Homelessness) • Intermediate tier redesign - Stage 1 (additional beds) • Food & Nutrition Programme	PAHT, CMFT, MMHSCT, MCC		1,227	**1,227**		**1,227**
	• Frail older adults - primary care • Consultant outreach for the elderly • Early supported discharge (stroke) • Palliative care / End of Life • Intermediate tier redesign - Stage 2 • Homeless leg ulcer	PAHT, CMFT, MacMillan, MMHSCT, MCC			**-**	2,418	**2,418**
	Total		**2,216**	**1,227**	**3,443**	**2,418**	**5,861**

Manchester Local Development Fund / Better Care Fund Commitments			LDF 2014/15			BCF 2015/16	
Comm-issioner	**Scheme**	**Provider(s)**	**Existing £'000**	**New £'000**	**Total £'000**	**New £'000**	**Total £'000**
Central Manchester CCG[1]	• • • • • •	CMFT, Primary Care, MMHSCT, MCC	TBC	TBC	3,400	TBC	TBC
	Total		**TBC**	**TBC**	**3,400**	**TBC**	**TBC**
South Manchester CCG	• Post Discharge/Virtual Ward • Ambulatory Care • Primary Care • Community Pharmacy • Memory Clinic • Prescribing Plan • Telehealth	UHSM, Primary Care, MMHSCT, MCC	TBC	TBC	3,400	TBC	TBC
	Total		**TBC**	**TBC**	**3,400**	**TBC**	**TBC**
Manchester City Council[2]	• • • • • •	MCC	TBC	TBC	TBC	TBC	TBC

Manchester Local Development Fund / Better Care Fund Commitments			LDF 2014/15			BCF 2015/16	
Comm-issioner	Scheme	Provider(s)	Existing £'000	New £'000	Total £'000	New £'000	Total £'000
	Total		TBC	TBC	TBC	TBC	TBC
TOTAL							

Appendix 4/A – Timeline for development of the Better Care Fund

Date	Milestones
31 March 2014	• HWBB approval of plans developed for use of Local Development Fund in 2014/15
15 April 2014	• Agree five year performance targets, measurement and evaluation for new care models
31 May 2014	• New care models defined for the two remaining priority groups (Complex Adults, Children with LTCs) • Updated criteria and governance arrangements for submission and consideration of future business cases to be confirmed and agreed
30 June 2014	• Draft Section 75 Partnership Agreement prepared including proposals for risk management across the city • Outline business cases developed for the next wave of investment in the new care models within each locality • HWBB review outline cases for the next wave of investment • Agreement of operation of Local Development Fund including robust evaluation and decommissioning decision making.
31 July 2014	• Full business cases developed for investment • Locality evaluation report from first wave of investment to HWBB to support decisions about continuation of, or exit from, integration services in 2015/16
31 August 2014 - report to HWBB 10/09/14	• HWBB consider evaluation reports summarising Cost Benefit Analysis of first wave schemes and determine continuation or exit • HWBB review full business case proposals and approve wave two investment • Outline expenditure plans updated for approvals

Date	Milestones
30 September 2014	• Commissioning intentions confirmed to providers with supporting modelling and / or change in service cost base (continuation and / or notices for wave one + proposals for wave two investment) • Changes in future commissioning arrangements formally notified to providers (Manchester City Council host for pooled budget) • Outline expenditure plans revised for the Better Care Fund
March–December 2014	• Contractual changes in commissioner confirmed and service contract documentation drafted • Financial and activity baselines agreed in principle, inclusive of commissioning intentions and / or costs of new care models • Payment arrangements confirmed between partners to support financial transactions • Financial plans drafted for 2015/16 Better Care Fund (pooled budget) and submitted to HWBB for scrutiny • Section 75 Partnership Agreement submitted for final scrutiny
HWBB 28 January 2015 / 25th March 2015	• Draft (28/01/15) and final (25/03/15) financial plans approved by HWBB • Contracts formally signed • Section 75 Partnership Agreement signed
1 April 2015	• Better Care Fund live