Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 14 May 2014

Subject: Living Longer, Living Better: Progress Update

Report of: Citywide Leadership Group (CWLG)

Summary

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

Recommendations

The Board is asked to:

- Note the progress of the LLLB Programme since March 2014, particularly in terms of the successful BCF submission,
- Note the BCF related milestones for the 2014/15 financial year,
- Note the development of the governance aspects of the Fund and the Partnership Agreement required for the purposes of the pooled budget under Section 75 of the Health Act and the Local Development Fund,
- Note the indicative work programme for the performance monitoring and evaluation task and finish group,
- Note the progress made in delivering innovative delivery models on the ground in the three locality systems,
- Support the revised governance arrangements for the programme, noting the intention to strengthen the programme management function,
- Note the intention of the CWLG to present the draft five year Strategic Plan and draft Programme Plan for sign off at the July HWBB.

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.

Further progress updates on LLLB have been provided to the Health and Wellbeing Board in January 2014 and March 2014.

1. Introduction

2.1 This paper summarises the work of the City Wide Leadership Group (CWLG) for the LLLB programme from March 2014 to May 2014. The paper is split into five sections:

- Section One - General Update,
- Section Two - Revised Better Care Fund Plan and Work Plan 2014/15,
- Section Three - Performance monitoring and evaluation update,
- Section Four - Locality System Delivery Updates,
- Section Five - Compact on Governance & Management of Delivery.

2. SECTION ONE – General Update

2.1 The CWLG has, since the last HWBB update in March, concentrated its activity on securing investment through the Better Care Fund (BCF) to support the development of innovative new delivery models. The investment agreements and business case submission process were covered in detail in the last HWBB update in March, so will not be repeated here. However, section two of this report gives an update on the BCF work plan for 2014/15.

2.2 The three locality health and care systems (North, Central and South) are now in the process of implementing the new delivery models. Section four of this report gives an update on how implementation is progressing in each of the localities.

2.3 As a result of the BCF work, collaboration between the core partners has moved on a stage. In particular, all partners recognise the need to work closely to strengthen the performance monitoring and evaluation framework underpinning the new delivery models to ensure the success of the new models can be evidenced accurately. A working group has been established to drive this work forward, with the recognition that stronger links need to be developed between performance evaluation and financial evaluation to ensure both are mutually reinforcing. Section three of this report outlines progress in this area.

2.4 Over the next two months the CWLG will look to refresh the LLLB programme plan. The catalyst for this work will be the development of a five year Strategic Plan which will update the LLLB vision, objectives and milestones in light of: lessons learned over the last 12 months; the emergence of new opportunities for collaboration; the need to establish stronger links with other Public Sector Reform (PSR) programmes; and the desire to operate at more place based level, rather than being constrained by organisational boundaries. The CWLG is also keen to increase the input of mental health services in LLLB, and strengthen links with the Early Years Programme.

2.5 The Strategic Plan will also redefine the aims and objectives of the ‘enabling domains’, including in particular ‘Information Management & Technology’ , ‘Estates’, ‘Workforce’ and ‘Performance Monitoring and Evaluation’. Work on these domains has progressed, but the CWLG recognises the need for the

domains to have defined deliverables and milestones linked to the Strategic Plan, to increase the pace of delivery.

2.6 The delivery of the LLLB programme plan will be supported by new governance and organisational arrangements which will strengthen the delivery capacity of the CWLG. These arrangements are outlined in section five of this report.

2.7 It is the intention of the CWLG to present both the draft five year Strategic Plan and the draft Programme Plan for sign off at the July HWBB.

3. SECTION TWO - Revised Better Care Fund Plan and Work Plan 2014/15

3.1 Introduction

3.1.1 The final Manchester Better Care Fund (BCF) plan was submitted on the deadline to NHS England (NHSE) on 4 April 2014. The updated BCF plan incorporated a number of revisions to the draft version submitted on 14 February 2014, including Manchester's response to some feedback from NHSE in mid-March (Appendix 1), which included a 'Strengths, Weaknesses, Opportunities and Threats' (SWOT) analysis and a RAG rated dashboard.

3.1.2 Further information was also provided on an indicative resource within the BCF allocation to meet the new responsibilities for the Council arising from the Care Bill in April 2015.

3.1.3 This report sets out:

- The indicative resource within the BCF for the Care Bill,
- The feedback from NHSE received mid-Mar (Appendix 1),
- The key milestones that have been set to develop the BCF further in 2014/15.

3.2 Better Care Fund and Local Development Fund

3.2.1 The BCF for 2014/15 and 2015/16 is £32.671m and £42.890m as set out in the BCF Plan and shown in the table below. The BCF is being used in Manchester to form a development fund that will support service innovation, effectively acting as a catalyst for change in Manchester's health and social care system. In 2014/15, the resources available for investment in the new models have been agreed as £13.2m. This includes £10.2m derived from health budgets and £3m from adult social care and public health contributions. This increases to £21.4m from 2015/16 through additional NHS funding of £8.2m.

Breakdown of Better Care Fund	2014/15	2015/16
	£000	£000
Carers break & reablement	5000	5,000
Social care transfer from NHS	9,998	9,998
Disabled Facilities Grant	2,967	2,967
Social Care capital	1,485	1,485
New responsibilities under Care Bill		2,000
Local Development Fund	13,221	21,440
Total Better Care Fund	**32,671**	**42,890**

3.2.2 To facilitate implementation of the programme, it has previously been agreed by the Health and Wellbeing Board to set up a Local Development Fund (LDF). The LDF relates to new investment from the BCF and under the governance of the Health and Wellbeing Board, will serve as the vehicle through which the recurrent financial feasibility of the new models will be evaluated. The LDF will create the recyclable funds to enable the set up and transitional costs associated with achieving the required shifts of activity set out above and drive the scaling up and incremental narrowing of the gap between risk and confidence.

3.2.3 The Local Development Fund (LDF) 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,
- Capacity costs needed for the implementation of LLLB,
- Funding in relation to alliance contracting.

3.2.4 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 the scaling up of out of hospital integrated services.

3.2.5 From April 2015 the BCF will become a pooled fund governed by a Section 75 agreement to be hosted by the Council. The Section 75 will be drafted between partners over the following few months. The arrangements will need to recognise that as well as supporting the delivery of the Living Longer Living Better programme through the LDF, £19.5m of the BCF is committed to existing services commissioned by the Council and CCGs and that the Department of Health has identified that the BCF as a key enabler for the Council's new responsibilities under the Care Bill. The proposed governance and operational arrangements for the pooled fund will be recommended by the City Wide Leadership Group to the Executive Health and Wellbeing Group for approval by the Health and Wellbeing Board. The key milestones below set

out that a draft Section 75 agreement will be prepared for the end of June 2014.

3.2.6 In the longer term partners will determine the extent to which the LLLB programme will contribute to the efficiency challenge, through review of other services and funding that sits outside of the BCF to determine possible expansion of the pooled fund where it is reasonable and appropriate to do so.

3.3 Alliance contracting

3.3.1 Contracting and funding is one of the LLLB enablers and workstreams, with the aim of ensuring that care models are delivered coherently and that services are not fragmented by organisational, professional or specialty boundaries.

3.3.2 Central Manchester is piloting a new approach that aligns partners across central Manchester through a new alliance contract. The principle of this approach is to move away from the current situation where providers have individual contracts for their specific services, to one where providers sign up to a single, shared contract covering the whole health and care system. In this way, providers have contractual and financial incentives to work together as an alliance to deliver against shared outcomes.

3.3.3 This vision will take time to implement fully and Central Manchester is taking a phased approach. For 2014/15 it will be testing the concept of alliance contracting through a 'pre-alliance', which is a smaller scale alliance contract for development of new integrated delivery models for urgent care. Key elements of the pre-alliance contract are as follows:

- It is a single contract between two commissioners (Central Manchester CCG and Manchester City Council) and six provider organisations (Central Manchester Foundation Trust, Manchester City Council, GoToDoc, Manchester Primary Care Limited, Manchester Mental Health and Social Care Trust, North West Ambulance Service),
- It includes £2.791m new investments (funded by the CCG from Central Manchester's allocation of the BCF) aimed at developing new integrated care models. The contract has flexibility should commissioners wish to add new investments to the contract in year,
- Provider organisations will work together to achieve targets on a shared performance framework. This is one of the key innovations of the alliance contract as it gives more scope to use system level outcome measures rather than output measures for one organisation's part in the system. It also generates the need for closer working between organisations,
- The contract includes a set of principles, agreed by alliance partners, which state how they will work together. It also sets out the high level mechanisms through which alliance partners will work together (e.g. governance arrangements and board oversight). These principles are consistent with those agreed within the LLLB papers to the HWB.

3.3.4 The intention is to then expand the alliance contract in value and scope in later years, subject to its performance in 2014/15. Future alliance contracts would also incorporate financial incentives for achievement of performance targets – these are currently incorporated into bilateral contracts between the CCG and healthcare providers.

3.4 **Care Bill**

3.4.1 The Care Bill will bring extensive changes both to the delivery of social care services and the way services are delivered and funded in the future. There will be additional responsibilities for Local Authorities (LAs), increased demand for assessments for people who currently meet the costs of their own care and additional support for carers. The draft bill has now completed all its stages in the House of Commons and is due to return to the House of Lords for consideration of amendments on 7th May 14. The draft bill sets out that by April 2015 LAs have responsibility to:

- Ensure sufficiency and quality of 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 the LA has responsibility to ensure an individual assessment or carer assessment is carried out to determine if they meet national eligibility criteria for care services,
- For a person that meets eligibility criteria, determine if the individual requires LA support, what support would be appropriate and if that support would be chargeable,
- 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 and set up Independent Personal Budget,
- For those that do want LA support, help the person determine how needs are to be met through a Care and Support Plan and review.

3.4.2 There are significant changes to how much people pay for their care from April 2016 which is expected to lead to a change in the Adult Social Care funding formula to LAs. During 2014/15 LAs will need to progress the development of IT systems to meet requirements of bill and in particular to provide a Care Account for each person with assessed eligible needs, setting out the notional costs accumulated towards the cap on care of £72k.

3.4.3 The following table is an extract from a new model on the NHSE web page indicating the level of resource within the Manchester BCF allocation that is intended to deal with the implications of the Care Bill. This shows that £1.5m of revenue costs and £0.5m of IT / capital costs have been identified for Manchester:

Care Bill implementation funding in the Better Care Fund (£135m nationally)		Manchester City Council Allocation £000s
Personalisation	*Create greater incentives for employment for disabled adults in residential care*	*33*
Carers	*Put carers on a par with users for assessment.*	*181*
	Introduce a new duty to provide support for carers	*360*
Information advice and support	*Link LA information portals to national portal*	*0*
	Advice and support to access and plan care, including rights to advocacy	*271*
Quality	*Provider quality profiles*	*54*
Safe-guarding	*Implement statutory Safeguarding Adults Boards*	*88*
Assessment & eligibility	*Set a national minimum eligibility threshold at substantial*	*437*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*48*
	Clarify responsibility for assessment and provision of social care in prisons	*72*
Veterans	*Disregard of armed forces GIPs from financial assessment*	*27*
Law reform	*Training social care staff in the new legal framework*	*50*
	Savings from staff time and redu-ced complaints and litigation	*-148*
Total		***1,473***
IT	***Capital investment funding including IT systems (£50m nationally)***	*544*
Grand Total		***2,017***

3.4.4 Further work is needed to understand how these values compare to the original estimate of £2m for the Care Bill in the BCF plan before any adjustments will be made to financial plans. A major unknown element in progressing the financial modelling is the numbers of people that currently self-fund their own care and the number of carers that will require support.

3.4.5 The Association of Directors of Adult Social Services (ADASS) has provided a model developed by Surrey County Council to be used to estimate costs locally. A few Councils, including Manchester, are testing the model. Whilst there are concerns amongst LAs with the value of the model, LAs remain committed to using a single modelling tool that will facilitate a consistent approach in identifying all cost implications. In the North West ADASS group is considering the use of development funding of £300k provided by the Department of Health to the 23 North West Authorities to provide support with this work.

3.5 Revised Better Care Fund plan

3.5.1 The Better Care Fund plan was updated in light of both the feedback from NHSE (Appendix 1) on the draft plan submitted in February 2014 and general

developments in Manchester since the initial submission. The feedback indicated a reasonably good position in terms of Manchester's BCF, with a significant number of 'conditions' rated as 'green or amber'. Key areas of good practice included:

- Partnership working and strategic provider representation on the Health and Wellbeing Board,
- Early implementation of investments – 'catalyst' funding,
- Co-production,
- Integrated multi-disciplinary teams.

3.5.2 The only 'Red' rated area was in respect of capital costs. This remains a gap in the revised submission and is dependent upon the pace of development of the Estates work-stream of the LLLB.

3.5.3 The revised BCF plan submitted on 4th April 2014 seeks to address the weaknesses and threats based on the latest position with the programme agreed through the City Wide Leadership Group (CWLG).

3.5.4 The metrics and outcomes table was revised to include performance targets for 2014/15 based on work completed through the CWLG. A key change in relation to performance targets is the removal of performance related pay elements of the BCF (previous policy was that up to 25% would be performance related, depending upon achievement of targets in 2014/15 and payable in 2015/16). A separate report on the performance monitoring of the programme is provided to the Executive HWB Group.

3.5.5 The CWLG developed criteria by which each locality system CCG evaluated a series of business cases that sought to draw down funding from the BCF to maintain or develop new delivery models – as detailed in the LLLB Update Paper to the HWBB in March 2014. These investment decisions rested with each CCG, and were made at different stages through March 2014. A summary of these business cases is being prepared to focus upon the key assumptions underpinning each case and demonstrate how the overall financial benefit is comprised, as well as highlighting other key assumptions (e.g. costs and performance measures).

3.5.6 Section three of this report outlines how the development of a comprehensive performance monitoring and evaluation framework is being prioritised, which will link the operational and financial evaluation of the new delivery models. This in turn will inform decision making related to the continuation of, or exit from, these new delivery models (see milestone table below).

3.5.7 The Finance template now provides an estimated recurrent financial benefit arising on the business cases developed to date. These are set in the context of the five year targeted acute activity reductions for the Manchester CCGs, as agreed with the three Manchester acute providers. Activity shifts in the template correlate with the activity reduction trajectories submitted in the CCGs' financial plans.

3.6 Key milestones

The BCF plan includes a range of high level milestones to describe the key financial aspects of work required to develop the plan and the BCF formal governance arrangements during 2014/15. These are highlighted below to ensure that focus is maintained on the significant workload facing all partners of the LLLB programme, particularly in the first half of the year.

Date	Milestones
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 • Draft locality evaluation reports 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
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
December 2014 –	• Contractual changes in commissioner confirmed and service contract documentation drafted

Date	Milestones
March 2015	• 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 • Section 75 Partnership Agreement signed • 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	• Local Development Fund live

3.7 Recommendations

3.7.1 The Health and Wellbeing Board is requested to note and comment upon:

- The current status of the BCF,
- The milestones proposed for 2014/15,
- Development of the governance aspects of the Fund and the Partnership Agreement required for the purposes of the pooled budget under Section 75 of the Health Act and the Local Development Fund

Appendix 1 – NHS England feedback on the 14 February 2014 BCF Submission

Operations and Delivery BCF: (BCF tool and SWOT analysis separate document)

- Links into the LLLB programme which is a key part of the CCG's Strategic Plan.
- To deliver Integrated Health and Social Care teams across the localities adapted to local needs but following the same principles.
- Complex as 1 LA but 3 CCGs.
- GP issues may impact on the delivery of the Integrated Teams and the lead clinician

CONDITIONS	Manchester CCGs	
Vision		
Consistent with wider CCG strategic plan		LLLB is a key part of each CCG's plan and strategy
Schemes and services well described		Section 2a,b & c
Plans jointly agreed		
Single plan		One plan for the 3 Manchester CCG's however there will be local variation
Sign by HWB / Council / CCG		States who and what level (no signatures)
Clarify how boundary differences handled?		Say N/A as 1 council for the 3 CCG's – however 3 localities and 3 acute providers involved.
Engage with all providers affected by the fund		Indication all providers are engaged 1c
Shared view of future shape of services (capacity and W/F requirements)		References the LLLB Business case and
Clear implications for local providers outlined		Implies there will be issues however not yet completed the work
No negative impact on quality of MH services		Indicates the MH Trust is a partner but does not talk about service provision
Protection for social services spend		
How will local adult social services be protected (definition local agreed)		BCF (£9.998m)to support in 2014/15. Care Bill implications to be funded through additional allocations from April 2015. Talk about service review in 3 areas 3a
DH guidance – support adult s/c services with a health benefit		Implied but not clearly stated
DH guidance – LA agree with partners how funding could be best be used in social care and outcomes expected		High level as above

DH guidance – Councils and CCGs have regard to JSNA and commissioning plans		Talks of aligning plans 2c
DH guidance – LA and CCGs demonstrate how make a difference to social care services and outcomes compared with no transfer.		High level 2a - LLLB
Carers breaks		Nothing specific
Capital costs		Can't see reference to this
New care bill duties and min eligibility criteria threshold		High level reference in section 3a
7 day services		
7 day services to support discharge and prevent unnecessary admissions at weekend – if not, why not?		Different positions across the 3 CCGs, the H&WB board will sign off – some examples of current 7 day working included. 3b
Better data sharing and NHS no.		
NHS no. as primary identifier		
Progress towards systems and processes which allow safe and timely sharing of info		Phased roll out of a single care record
Using NHS no and if not, by when?		
Pursuing open APIs		
Appropriate IG in place (in line with Caldicott2)		Established framework
Joint approach to assessment		
% population receiving case management and have accountable lead professional		Phased roll out 38 practices have this in place The population has been segmented into broad risk cohorts 3d
% receiving self-management help		Self-care is a measure in the LLLB programme but no ref in the BCF plan narrative
Dementia		Not mentioned in the narrative but is the locally chosen metric 'early diagnosis rate for people with dementia'
GP leadership (a/c professional)		Planned and phased roll out
Agreement on consequential impact on acute		
Provider by provider – impact?		High level ref but talks of CBA to be completed
Public / service user engagement in plans		Mention 2 public feedback events and a healthier together event in May – also talks about communications objectives

Political buy-in		Both the Council and H&WB engaged
Parity of esteem (MH services)		Limited reference with no substance
Risk		
Risk mitigation plan (impact on NHS and social care delivery and steps if volumes don't change as planned)		Appendix
Finance		
Min amount to be pooled		
Contingency for targets not being met		0 in 2015 other TBC
Metrics		
Realistic ambition for each of the 5 national metrics		TBC
Chosen local metric taken from national menu		2.6i 'early diagnosis rate for people with dementia'

Manchester BCF Template - 'SWOT' Analysis

Key Strengths

- BCF invested alongside circa £6m 'development fund'. 'Catalyst'
- Strategic provider representation on H&WB , input to local plans, new delivery models and Partnership Networks (wide ranging)
- Designing a template of how the new delivery models will be implemented
- Strong patient/user engagement & 'coproduction' with providers
- Integrated multi-disciplinary teams operating out of 38 GP practices
- 'Living Longer Living Better' the programme of integrated care
- 'Mrs Pankhurst' – articulates vision for services on the ground
- Identified 5 priority cohorts for investment & new models of care

Main Weaknesses

- **Minimal quantifiable data on cost pressures or deflections**
- Difficult to ascertain split by CCGs – any local differences/issues?
- Commissioning 'cycle' does not appear to seek financial 'balance'
- No quantifiable data given for *Implications for the acute sector*
- Comprehensive expenditure plans for all of the new delivery models not yet in place in each of the next five financial years.
- Uncertainty around ability for *Protecting social care services*
- No timescales for implementing *7 day services to support discharge*
- No indication of what proportion of spend attributable to 5 cohorts

Opportunities

- 1) Scale up good work already in place and spread it across City
- 2) Phase implementation of new and innovative delivery models
- Out of hospital integration to happen at scale and speed
- Exploring Evaluation of the LLLB Programme
- Enabling work on Data Sharing, Estates and Workforce
- Governance may be streamlined, as appears 'heavy'
- Identifies how BCF monies can support Care Bill implementation
- Implementing on a phased basis the use of a single care record
- **Financial model developed to capture current health and social care expenditure across the five priority target population groups. This must be given top priority.**

Threats

- **Lack of evidence of ability to quantify/analyse and cost current baseline, transition and new delivery models**
- Pace & scale protracted if residents must be able to 'touch and feel' what integrated care means for them
- Evidence from other sources (Deloitte) indicate the FMOC are more costly than the current service delivery models
- £2m allocated to the phased implementation of new models 'feels' low
- Not clear how new models will deliver sustainability across the health economy

4. SECTION THREE – Performance monitoring and evaluation update

4.1 Background

4.1.1. The development of a series of new delivery models as part of the LLLB programme, backed up by the establishment of a Local Development Fund (LDF) to enable the implementation of these new delivery models during 2014/15, is evidence of the ongoing commitment of MCC, the three Manchester CCGs and local providers to working together in order to develop new and innovative approaches to the delivery of more integrated health and social care services for key sections of the population.

4.1.2. All partners recognise the need to develop a more rigorous and disciplined approach to monitoring and evaluating the impact of these new delivery models at both macro (strategic) and micro (operational) levels and thereby better understand their contribution to some of the other changes going on across the health and social care system, including the Healthier Together programme and the implementation of the Care Bill. The evidence derived from these evaluation activities will help to inform future investment decisions about whether to increase the pace and scale of these new models or to close them down.

4.1.3. North, Central and South Manchester CCGs have all established local evaluation programmes which are now starting to generate evidence of the impact of the work being undertaken as part of the Integrated Care Pilots in different parts of the city. As part of the approval process for the proposed areas of investment from the LDF/BCF for 2014/15, the authors of each business case are also required to demonstrate how they will put rigorous monitoring and evaluation processes in place in order to ensure that commissioners can measure the impact of this investment.

4.1.4. A report to the Exec Health and Wellbeing Group on 9th April 2014 recommended that a more systematic programme of work be put in place in order to improve oversight and monitoring of progress in relation to performance measurement and evaluation and ensure that this area of work is established as a mainstream activity within of the governance structure of LLLB. The aim of this work is to help the HWBB to understand:

a) How the health and social care system as a whole is performing in relation to shifting care out of secondary care into the community and producing the required efficiency savings,
b) Whether the three Integrated Care Pilots and the proposed NDMs have the necessary systems and processes in place in order to evidence whether their work is delivering (or will deliver) improved outcomes and the expected financial benefits for the target cohort(s).

4.1.5 This is part of the creation of a broader performance management and learning system that will enable the tracking of progress and the creation of mechanisms for the rapid spread of experiential learning across the city.

4.2 Recent and future activities

4.2.1 *Performance measurement framework*

4.2.2 The development of a draft performance measurement framework for LLLB as a whole was described as part of a paper to the Exec HWBB on 18th December. It is now necessary to move beyond the definition and development stage and embed the work into routine reporting and performance management processes, aligned to contracting mechanisms and financial monitoring systems, so that existing performance indicators and other sources of data can be synthesized into a meaningful and relevant report. In particular, there is a need to further develop the existing LLLB measurement framework by identifying a small set of commonly agreed measures which can be reported to both MCC and the three Manchester CCGs (at citywide and CCG level) on a regular basis and embedded into provider contracts where it is appropriate to do so.

4.2.3 As a starting point, a review of existing performance indicators has been carried out in order to understand better the range of statutory and non-statutory measures of health and social care activity across the city and the overlaps between these.

4.2.4 Work is now underway to construct an interim citywide dashboard based on the performance monitoring tool that has been developed for the Central Manchester Clinical Integrated Care Board (see below). This has a strong degree of overlap with the previously agreed LLLB measurement framework and the Better Care Fund (BCF) metrics and it is therefore suggested that this forms the basis of a citywide performance dashboard, subject to negotiation with North and South Manchester CCGs and the City Council. This may need to be further refreshed and strengthened following the production of a 5 year Strategic Plan for the LLLB programme.

4.2.5 *LLLB Evaluation Task and Finish Group*

4.2.6 In line with the recommendation to the last Exec HWBB, an Evaluation Task and Finish Group has now been established. The primary aims of the Group are:

- To review existing evaluation activities in respect of health and social care integration across North, Central and South Manchester,
- To agree the required outputs from future evaluation activities in relation to the new delivery models for adults at the end of life, adults with long term conditions and frail older adults/adults with dementia, including the proposed areas of investment from the LDF/ BCF for 2014/15,
- To agree a programme of work to help support and deliver these evaluations, including appropriate contracting arrangements and links with GM PSR work,
- To agree roles and responsibilities of partners in respect of evaluation,
- To agree timescale and reporting mechanisms for emerging outputs from evaluation programmes.

The Group met for the first time on 23rd April and meeting dates for the next 6 months have been set. In governance terms, it is proposed that group acts as a time-limited sub-group of the Exec Health and Well Being Group but uses the LLLB City Wide Leadership Group as a sounding board for resolving ongoing issues.

4.3 **Indicative work programme for May/June 2014**

4.3.1 Following the first meeting of the Evaluation Task and Finish Group an indicative work programme for the next two months has been proposed. The proposed work programme can be split broadly in to two parts:

a) A review of the current performance measurement and evaluation activities within each of the CCG multi disciplinary teams in order to inform learning and support the sharing of best practice. More specifically, there is a need to:

- Audit the processes in each area for producing metrics, including what systems are used to capture and record activity,
- Identify and document what, where and how data items are being captured,
- Explore how data are analysed and performance reports are generated,
- Understand what evaluation metrics are being used in each area and exploring where there are overlaps and gaps across the City.

b) An assessment of the planned performance measurement and evaluation activities in respect of the proposed areas of investment from the LDF/ BCF for 2014/15. This will involve:

- Collating details of all of the new delivery models/business cases agreed through the LLLB BCF/LDF process,
- Systematically reviewing new delivery models/business cases to assess how strong they are in respect of evaluation and monitoring,
- Identifying how the measurement and evaluation requirements of the existing LLLB BCF/LDF business case process can be strengthened.

4.3.2 It will be important to ensure that this work is joined up with the work that the GM Public Service Reform Team are leading in terms of Cost Benefit Analysis (CBA) of local integrated care plans and developing the wider evidence base underpinning the Healthier Together programme. It is proposed that an initial output from these discussions will be a simple 'check list' consisting of a set of key criteria (based on the GM CBA model) that all CCGs can use to help them assess the monitoring and evaluation aspects of the LLLB business cases in a more consistent manner.

4.3.3 The ultimate aim of the work is enable the LLLB Programme to start to function as a ‘learning system’ whereby best practice is identified, developed and shared across the whole of the health and social care system in Manchester as a matter of course, rather than on an exceptional basis.

4.3.4 Following this paper, regular updates will be provided to the HWBB pending the production of a more comprehensive report describing the early findings of the evaluation work on 10th September 2014.

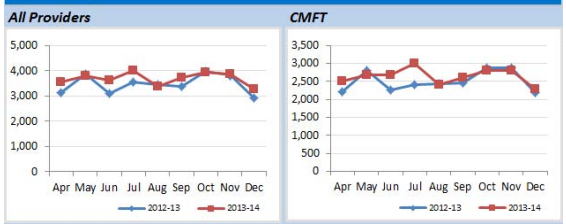
4.4 Resource Implications

4.4.1 Given the importance of this work to the programme as a whole, it is vital that these activities are adequately resourced. It is proposed that the work should be co-ordinated by the new LLLB Programme Office with the support a dedicated Project Manager for Performance Monitoring. We will also continue to explore the academic links that exist through the Manchester Academic Health Science Centre (MAHSC) in order to enlist the support of academic colleagues to help formulate, and potentially carry out, further evaluation of specific aspects of the work programme (e.g. patient/client satisfaction, quality of care etc).

Proposed LLLB Performance Dashboard (draft)

Metrics included in this dashboard will updated monthly, according to data publication schedules

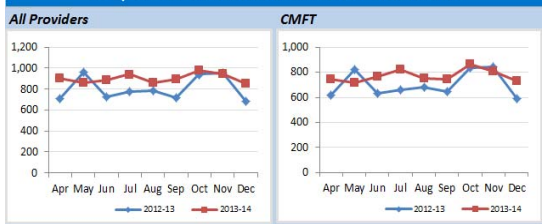
Outpatient 1st Attendances: All Sources of Referral



	All Providers		CMFT	
2012-13	31,162		22,472	
2013-14	33,157	↑	23,788	↑
% Change	6.4%		5.9%	

Source: SUS

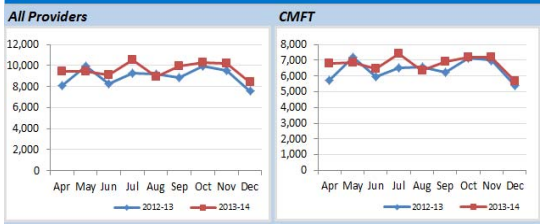
Outpatient 1st Attendances: C to C Referral



	All Providers		CMFT	
2012-13	7,268		6,332	
2013-14	8,116	↑	6,948	↑
% Change	11.7%		9.7%	

Source: SUS

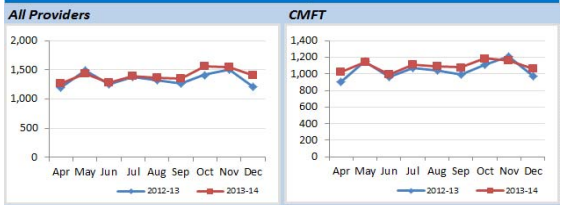
Outpatient Follow Up Attendances



	All Providers		CMFT	
2012-13	80,772		57,669	
2013-14	86,302	↑	60,891	↑
% Change	6.8%		5.6%	

Source: SUS

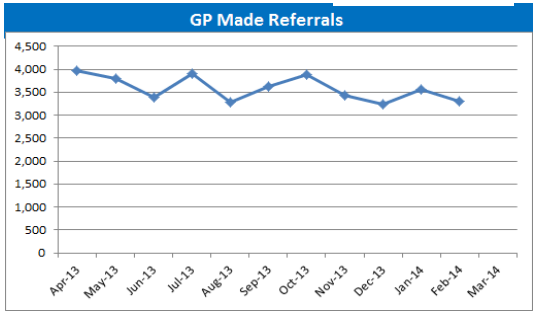
Total Admissions: Daycase + Elective



	All Providers		CMFT	
2012-13	12,016		9,420	
2013-14	12,625	↑	9,842	↑
% Change	5.1%		4.5%	

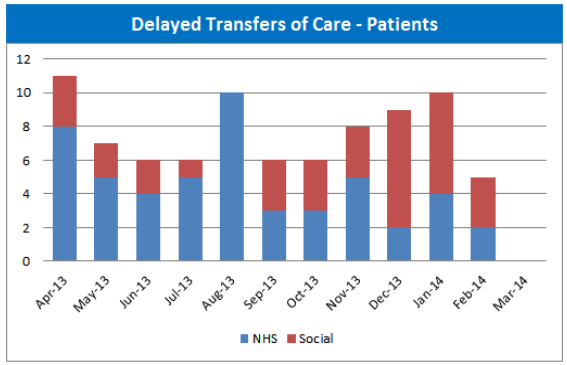
Source: MAR

GP Made Referrals



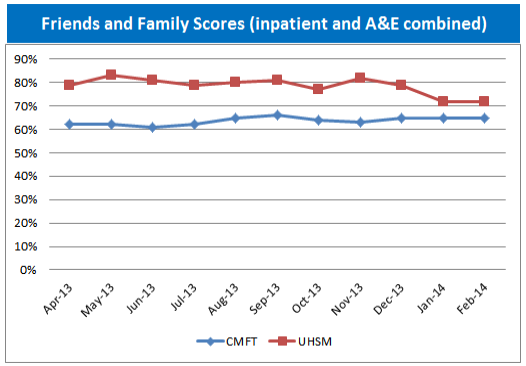
Source: MAR

Delayed Transfers of Care - Patients

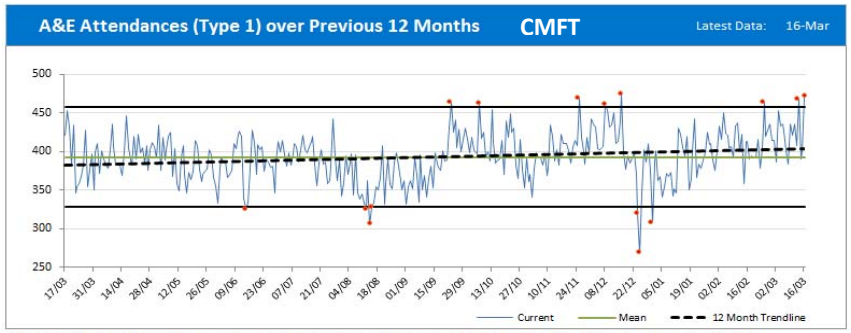


Source: NHS England

Friends and Family Scores (inpatient and A&E combined)

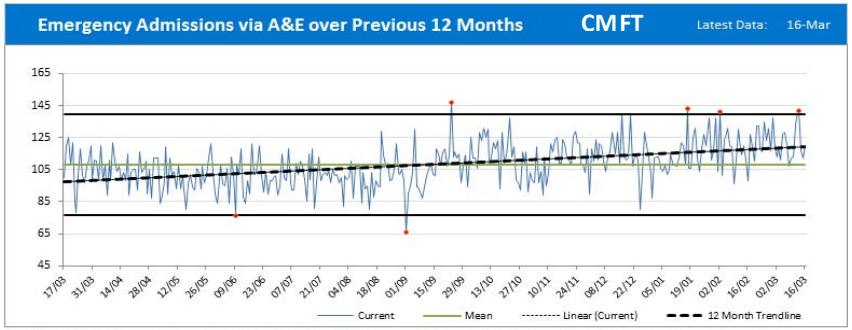


Source: NHS England



Attends for last 3-months v same period last year: 2013-14 - 36,261 ; 2012-13 - 36,096. Increase of 0.5%

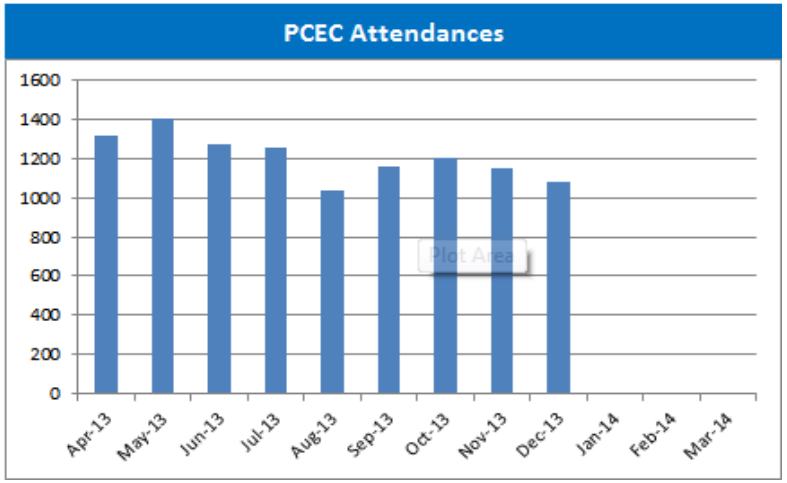
The chart shows a very slightly increasing trend in A&E attends over the last 12 months. Attends in the latest 3 months are only 0.5% higher than in the same period in 2012-13.



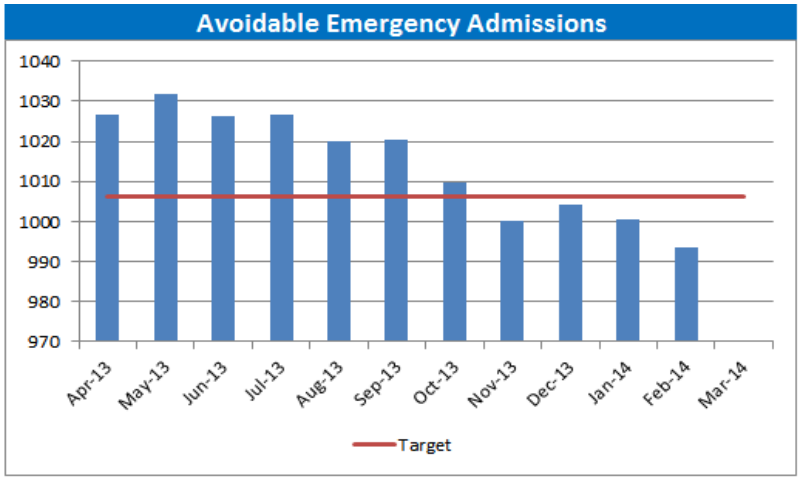
Admissions for last 3-month v same period last year: 2013-14 - 10,664 ; 2012-13 - 9,372. Increase of 13.8%

There is a significant upward 12-month trend. The number of admissions in the last 3 months is 13.8% higher than for the same period last year. Last month's report showed a 14.6% increase on the 2012-13 equivalent period so there is a slight slow down in the increase. 142 admissions on 14th Mar was above the control limit.

Source: Weekly Sitreo



Source: Graphnet



Source: SUS

5. SECTION FOUR - Locality System Delivery Updates

5.1 North Manchester

This update seeks to provide assurance to the HWBB of the implementation of the new delivery models in North Manchester using the Integrated Intermediate Tier development by way of operational example. Three outline new delivery models (NDM) for 'frail older adults and adults with dementia', 'care at the end of life' and 'adults living with long term conditions' were approved by the North Provider Partnership Forum in February 2014 and by the Joint North Manchester Health and Social Care Community Clinical Board in March 2014. Each NDM has nominated managerial and clinical leads that are responsible for the ongoing implementation. Accountability is to the Board via the partnership forum.

5.2 North Manchester Intermediate Tier – implementation

The development of an integrated intermediate tier forms part of the NDM for frail older adults and adults with dementia. The objectives of developing such a model are:

- To integrate current health and social care intermediate care and reablement services into a single service – details of current services in paragraph 5.3, below,
- For MCC and NMCCG to jointly commission the service,
- To enable short term rehabilitation and re-enablement following a crisis to enable a return to independence,
- To maximise the number of patients/customers who can be stepped up to the intermediate tier rather than stepped down following hospital admission,
- Increase capacity in intermediate tier services to support care outside hospital,
- To remove overlap and duplication between services, particularly home based intermediate care and reablement,
- Improve the level and quality of service for intermediate tier patients with mental health needs e.g. dementia,
- To have a single health and social care assessment for patients/customers using the intermediate tier,
- To maximise opportunities to re-think use of the workforce including scope for using generic workers and assessments and utilise specialist expertise where that is needed,
- Ensure effective pathways/links with other outside hospital services.

5.3 The scope of the intermediate tier will include the following current services:

- Intermediate care beds commissioned by NMCCG and provided by Pennine Acute Hospital Trust (PAHT) – 15 residential beds at Henesy House. National Audit for Intermediate Care (NAIC) data showed NMCCG was 5th lowest nationally for its spend per head on intermediate care beds,
- 25 intermediate care places in people's own homes commissioned by NMCCG and provided by PAHT – NAIC shows NMCCG have average spend for this element of intermediate care,
- Crisis response pilot commissioned by NMCCG provided by PAHT – current nine month pilot with an multidisciplinary team providing care for up to 72 hours for people who would previously have been admitted to hospital,

- Navigator services commissioned by NMCCG provided by PAHT – intervention at A&E/Medical Assessment Unit/short stay areas of NMGH enabling rapid, safe discharges into out of hospital settings,
- Reablement commissioned and provided by MCC.

5.4.1 The intermediate tier development has a project steering group to oversee and manage the work plan. The steering group comprises members from each of the stakeholder organisations (MCC, NMCCG, PAHT, MMHSCT) and meets fortnightly. Project sponsorship and project management is being provided by MCC. Workstreams are established for model design (PAHT led) and finance and contracting (NMCCG led). Additional workstreams will be set up for Communications, Workforce, IM&T etc when the model design is clear. Governance of the project rests with the Joint North Manchester Health and Social Care Community Clinical Board.

5.5 The implementation is supported by the development of two business cases;

- The first is a business case for temporary additional intermediate care beds (reflecting current low numbers),
- A capital business case to develop a building on the NMGH site to locate the bed based intermediate care.

5.6 Timescales:

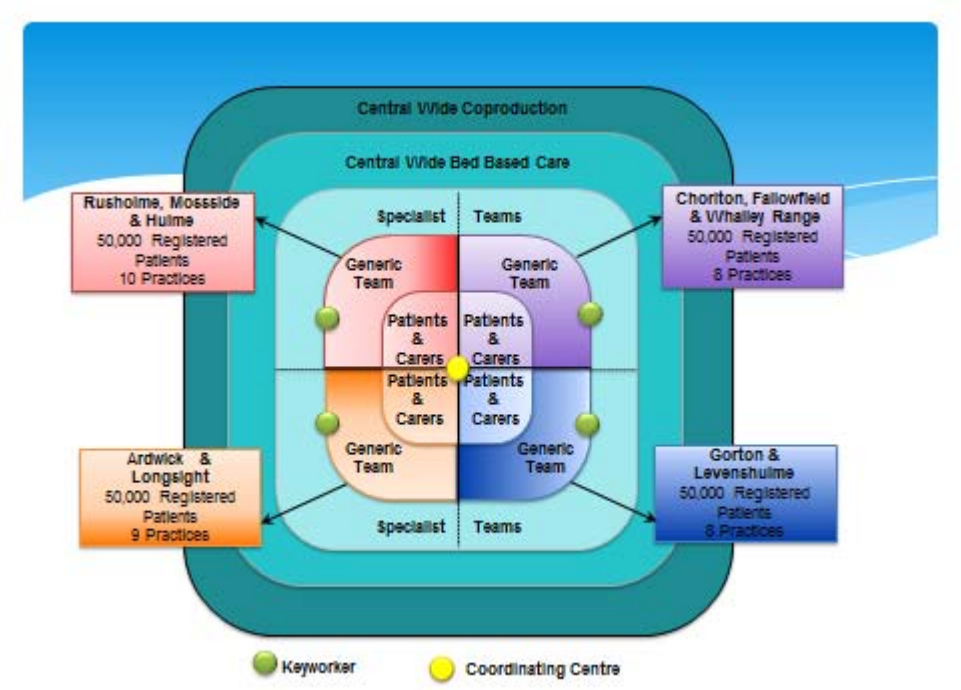
- Temporary beds business case – May 2014,
- Agreed design for intermediate tier – June 2014,
- Business case for intermediate tier to go through NMCCG and MCC business case processes by September 2014,
- Implementation of the new intermediate tier model and commissioning arrangement from April 2015.

5.7 The current intermediate care, crisis response and reablement expenditure formed part of the BCF submission for 2014/15. The temporary beds would be funded from the 2014/15 BCF. The capital case for the beds on the NMGH site will be funded separately. Any additional funding requirements for the integrated tier model would form part of the BCF for 2015/16.

6. Central Manchester

6.1 Three NDMs have been agreed in Central Manchester – as with the North update, above, they are concerned with frail older people and adults with dementia, adults with long term conditions, and adults at the end of life. The NDMs have been designed over a number of months with up to 12 different partners and have been agreed by the Central Provider Partnership (CPP), Central Integrated Care Board (CICB) and the HWB. Full details are in papers to these boards.

6.2 All new delivery models are formed around a generic model for Central Manchester which is focused on the four localities as seen in the diagram below. The model builds on current generic and specialist services, integrating them into one health and social care system. Central recognise the need to co produce services in the future, co ordinate both provision and delivery across the system and ensure carers are central to how services are sustained the future.



6.3 The vehicle for driving this change will be the CPP. It is made up of 9 organisations, is chaired by Gill Heaton (Deputy Chief Executive and Chief Nurse - CMFT) and accountable to the CICB – see diagram below.

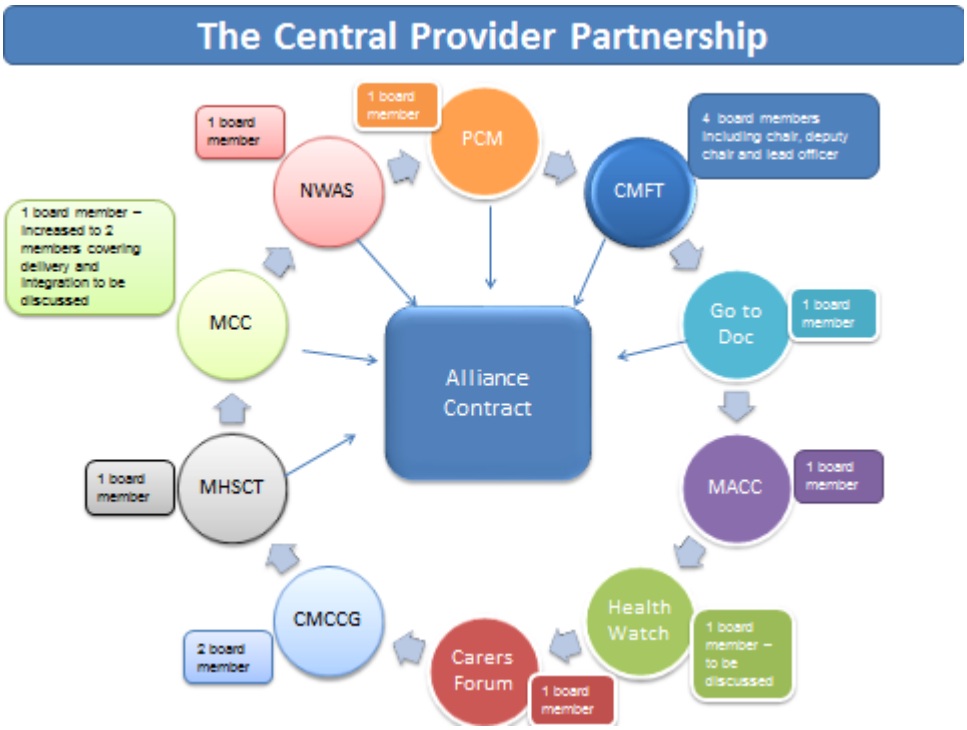
6.4 The CPP has had a development session led by the Kings Fund last month. It has established its new way of working and goals, which are:

- By 2020 20% more care is provided in the community rather than in a hospital setting,
- By 2020 CPP will have implemented the NDMs for living longer living better,
- By 2020 CPP will be working and behaving differently to enable an innovative vehicle of change in the system.

6.5 The CPP has agreed to prioritise two main objectives in 2014. These are to develop the three new delivery models within the generic locality model, taking as its methodology complex adaptive systems. It aims to deliver a bottom up approach to changing how care is delivered within communities through locality working. Secondly, to deliver the agreed alliance contract in relation to the BCF projects as well as the performance framework which has been agreed between all alliance partners.

6.6 As part of the BCF, accountable to the CPP, it has prioritised the further development of our integrated care model in the following areas: practice integrated care teams; COPD integrated care pathway; community IV therapy team; intermediate care assessment team; continuing health care; end of life residential homes; extended GP hours; and alternative to transfer to hospital. A proactive

elderly care team is also being established and the establishment of an integrated care homes model is being explored. The CPP assessed all BCF business cases and made recommendations to the commissioners for the investment in the BCF, in so doing it prioritised areas that have already been established and need to continue to develop to create a sustainable locality model.



6.7 The CPP believes it needs to create an environment where LLLB will start to be a transformative way of working within Central, where the system strives to leave a sustainable legacy of changed services by empowering patients, carers, practitioners and the communities they are delivered in. Early wins will be sought in collaborative working in a different model as alliance partners, and how the NDM begins to be delivered in a more collaborative locality model in, and with, communities. The risks are well documented in terms of time and resource. However more crucial is the need to have a changed approach to leadership and system wide development that enables and empowers those people in our systems to be able to behave, design and deliver services differently in the future.

6.8 The Central CCG has also made a number of further investments recently that will contribute to the objectives of LLLB. Individual general practices have been invited to offer enhanced levels of care for dementia and management of heart failure. In addition primary medical services have been targeted specifically at the homeless population in two specialist practices. These developments will be performance managed by the CCG.

7. South Manchester

7.1 This short briefing is designed to provide an update for the HWBB regarding operational progress in the South Manchester locality as part of the LLLB programme.

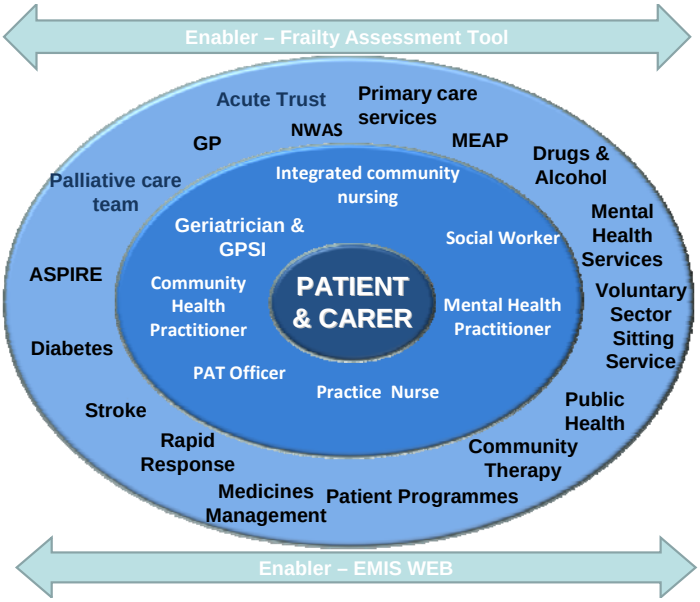
7.2 During November and December 2013, South focused upon the frail older population and adults at end of life for development of new service delivery models. South took the citywide LLLB outcomes framework from commissioners and used that as a basis for consultation with staff, stakeholders and partners which included health and social care colleagues, NWAS, Manchester Mental Health and social care Trust, specialist clinicians, the Manchester Carers Forum and the voluntary sector.

7.3 As a result of the consultation a business case was developed that incorporated the elements of integration and provision that South believe will improve the outcomes for the two population cohorts. South believe that these will improve patient experience and shift activity out of the hospital.

7.4 The enabling elements of the business case that are currently being planned and implemented are to:

- Implement remote IT devices for all community staff which will enable access to the primary care system – EMIS web and will enable real time access to shared records and patient information for staff,
- Develop plans to provide a single point of referral for community services – this may potentially be a citywide provision in collaboration with Central Manchester, North Manchester and MCC,
- Implement a frailty assessment tool that health and social care professionals and patients and carers can use, to identify frailty earlier and provide earlier interventions.

7.5 The operational implementation of the business case is focused upon the development of the current Neighbourhoods to move to an enhanced level of provision – see diagram below:-



7.5 As a result of the BCF implementation, the Neighbourhood teams will provide a rapid response service – in hospital and in a patient's home. This will enable swift discharge home and also support people at home, who may be becoming unwell; to avoid hospital admission if that is appropriate for them. The Neighbourhood Teams will be supported by additional Geriatrician and GPsi support to enable assessment and treatment to take place. Recruitment for these posts has commenced.

7.6 To support the End of Life service delivery model, an integrated Palliative Care Team is being developed, with care provided for all adults at end of life, irrespective of their disease, and to provide a service which will be extended during the out of hours period. Specialist providers of palliative care will also support our community teams with greater education in order to enhance the level of palliative care that is offered. Recruitment of physiotherapists, Occupational Therapists and Palliative Care Nurses is currently underway to support this development.

7.7 In South Manchester, the ambition is to develop an alliance of providers. The Partnership Provider Board is chaired by the South Manchester GP Federation Chair. It currently comprises of four organisations, however, based upon the experiences and learning of North and Central Manchester localities, terms of reference are being reviewed with a view to increasing membership to include voluntary and carer organisations.

8. SECTION FIVE - Compact on Governance & Management of Delivery

8.1 Introduction

8.1.1 The Executive Health and Wellbeing Group held on 12th February approved a paper on the governance and management of delivery arrangements for Living Longer Living Better for 2014/15. This proposed a tri-partite structure with collective leadership being exercised through the Health and Wellbeing Board Executive Health and Wellbeing Group and the Citywide Leadership Group; implementation being driven at locality level through Locality Integration Boards; and technical support and coordination being provided by a Programme Office. This is shown as Appendix 2. The EHWG also agreed in principle to £50k per partner allocation to create a £400k Programme Office budget for 2014/15.

8.1.2 EHWG asked for further work to be done to clarify the roles and responsibilities of each element of the system and for this to be described in a compact document. In addition, further details were requested on the proposed utilisation of the £400k budget for the Programme Office.

8.1.3 This paper sets out the roles and responsibilities of the collective leadership structure, the Locality Level Implementation Groups and the Programme Office. It also describes the proposed performance monitoring arrangements for Living Longer Living Better, and urges the EWHG to commit to continuing to invest in learning, development and leadership as the programme progresses.

8.2 Collective Leadership

The Living Longer Living Better programme is an ambitious plan for transformational change across health and social care which is actively engaging eight statutory bodies as partners. The collective leadership of LLLB is exercised in the following ways:

Health and Wellbeing Board

This is the overarching body with primary accountability for the Living Longer Living Better programme. It is also statutorily responsible for the disbursement of the Better Care Fund and the vehicle for giving effect to joint commissioning decisions. The Health and Wellbeing Board has a broader role than simply that of Living Longer Living Better, but in relation to the LLLB programme its role is as follows:

- Approve the overall vision and direction for health and social care integration across the City of Manchester,
- Approve pooled budget arrangements including the use of the Better Care Fund,
- Provide support and challenge in relation to proposed implementation plans,
- Seek assurance that plans are being implemented as set out and delivering the intended outcomes for Manchester residents,
- Role model the behaviours that will shape a collaborative culture which fosters effective partnership working.

The Executive Health and Wellbeing Group

This group reports directly to the Health and Wellbeing Board and is a forum in which Chief Executives from the partner organisations can work closely together to progress their joint interests. Again, it has a broader remit than LLLB but the EHWG is critical to LLLBs successful implementation. The Early Years Strategic Executive Group also accounts into the EHWG thereby allowing strong connections to be made between the programme and LLLB. The EHWG's remit includes:

- Operate as a key executive forum for shaping decisions on integrated working for recommendation to the Health and Wellbeing Board
- Ratify proposals on vision, implementation plans and business cases for approval by the HWB including in relation to the Better Care Fund and the development fund,
- Delegate key tasks to the CWLG and Programme Office in order to implement the agreed vision,
- Oversee the effective operation of a tripartite structure including collaborative leadership, Locality Implementation Groups and the Programme Office,
- Monitor progress against programme milestones and delivery of intended outcomes to collectively hold each other to account for successful implementation and the rapid spread of learning across the city,

- Ensure an appropriate balance between a citywide approach with a commitment to common service standards and outcomes as against the need for locality level service developments,
- Provide a forum for resolving conflicts, learning lessons and spreading best practice at CEO level and beyond,
- Foster innovation and creativity in the development of integrated services
- Role model the behaviours that will shape a collaborative culture which fosters effective partnership working.

Developing commissioning arrangements to support integration

LLLB has been successful in large part due to the spirit of collaborative working between commissioners and providers across the city.
The CCGs and City Council will need to work together to more closely align their commissioning activities. NHS England as the commissioners of primary care services and specialised services will also need to be involved in this work.
Reports will be brought back to the EHWG members as the work develops.

Citywide Leadership Group

The Citywide Leadership Group is the “engine room” driving forward the strategic development and implementation of LLLB under the guidance of the EHWG and HWB. Its role is:

- Deliver a programme of work (set out annually and reviewed quarterly) as agreed by the EHWG to progress LLLB,
- Make appropriate connections between LLLB and other relevant workstreams, including, for example, the Early Years programme, Healthier Together, Primary Care development and the commissioning of cancer and mental health services,
- Ensure locality plans are consistent with a citywide vision and service standards,
- Provide the key interface between strategic intent for LLLB and operational delivery,
- Oversee the development of an effective communications and engagement programme LLLB,
- Frame proposals on key issues for consideration by the EHWG and ultimately the HWB, eg business case prioritisation processes, performance measures, developments to support enabling work streams,
- Develop deep expertise in health and social care integration through collaboration with other communities, nationally and internationally, and with NHS England, Department of Health think tanks and other sources of information and advice,
- Regularly review performance data and programme milestones and ensure collective action is taken should the programme be off track,
- Role model the behaviours that will shape a collaborative culture which fosters effective partnership working.

Executive Sponsor for LLLB

It is important that there is a consistent thread between the activities of the HWB, EHWG and CWLG. The programme will require drive, energy and commitment to be provided at executive level. It is therefore recommended that the Strategic Director for Families Health and Well Being for Manchester City Council take on the role of Executive Sponsor for the LLLB programme. In this role the Director will be a member of both the HWB and EHWG and will also act as Chair of the CWLG. This is a critical role in ensuring coordination, delivery at pace, and the implementation of the vision generated by the EHWG and HWB.

CWLG Reference Group

The CWLG have to date used a clinical reference group as a 'sounding board' to test out the development of LLLB proposals. The membership of this group has recently been broadened to include voluntary sector representatives. Its membership and mode of operation will be reviewed to ensure it supports these new governance arrangements appropriately. It is useful to note in relation to General Practitioners that there are a variety of routes for engagement in addition to the Reference Group. These include the representational role of the LMC, GPs as commissioners through the CCGs, and GPs as providers as part of the locality implementation arrangements

8.3 Locality Level Implementation

LLLB is founded on the premise that there will be a common set of commissioner developed care models for the city as a whole to ensure a common level of service standard delivered and equality of access and outcomes. However, it is also the case that different patterns of provision (particularly in relation to NHS care) exist in different parts of the city and that in NHS terms the 3 CCGs have separate contractual arrangements with local providers. As a consequence it is appropriate that implementation of LLLB is driven a locality level with the development of new forms of service delivery moving at pace. As this is done there will be a strong emphasis on close cooperation, rapid spread of learning and monitoring of outcomes to provide assurance that all residents of the city are receiving more integrated and effective services no matter where they live.

The role of Locality Level Implementation Groups is as follows:

- Ensure close collaboration between commissioners and providers at locality level to secure LLLB implementation
- Develop, approve and implement business cases to secure new developments and service changes consistent with the LLLB vision
- Ensure that citywide service standards and outcome measures set out in the LLLB care models are adhered to during locality level implementation
- Develop appropriate financial and contractual arrangements to give effect to LLLB within the specific provider and commissioner relationships within North, South and Central respectively
- Monitor progress against programme milestones and intended outcomes at locality level and take corrective action as appropriate

- Role model the behaviours that will shape a collaborative culture which fosters effective partnership working.

8.4 Programme Office

Effective programme management will be the glue that holds the programme together. However, it is important to recognise that the Programme Office function as described here is a technical support one – the executive leadership and direction for setting out the vision for LLLB and ensuring that it is implemented rests with the collective leadership structure and the locality implementation arrangements respectively. The role of the Programme Office therefore includes:

- Ensure close joint working between the three elements of programme governance – the collective leadership; locality level implementation arrangements; and the Programme Office itself
- Provide a repository of knowledge about best practice in health and social care integration and act as key conduit to developments in regional and national policy and practice
- Develop and manage performance monitoring systems for Living Longer Living Better which track progress against milestones and intended outcomes, and report this to the CWLG and EHWG
- Oversee and coordinate the work of enabling domains (finance, IM&T, workforce, estates) and ensure that they make an effective contribution to programme delivery
- Manage the communications and engagement function for LLLB
- Coordinate the flow of LLLB business on an annual cycle, ensuring timely decisions are taken by EHWG and HWB, supported by the CWLG and Locality Implementation Groups

In order to fulfil these functions it is proposed that the Programme Office consists of a Programme Manager; a Project Lead for the Enabling Domains; a Project Manager for Performance Monitoring; and a Communications Lead and Communications Officer together with Programme Support posts. This does not utilise the full proposed Programme Office budget and it is recommended that monies are retained for targeting in-year at key issues at the discretion of the EHWG on recommendations from the Programme Office and CWLG. A more detailed note on the operation of the Programme Office is attached as Appendix 3.

8.5 Performance Monitoring

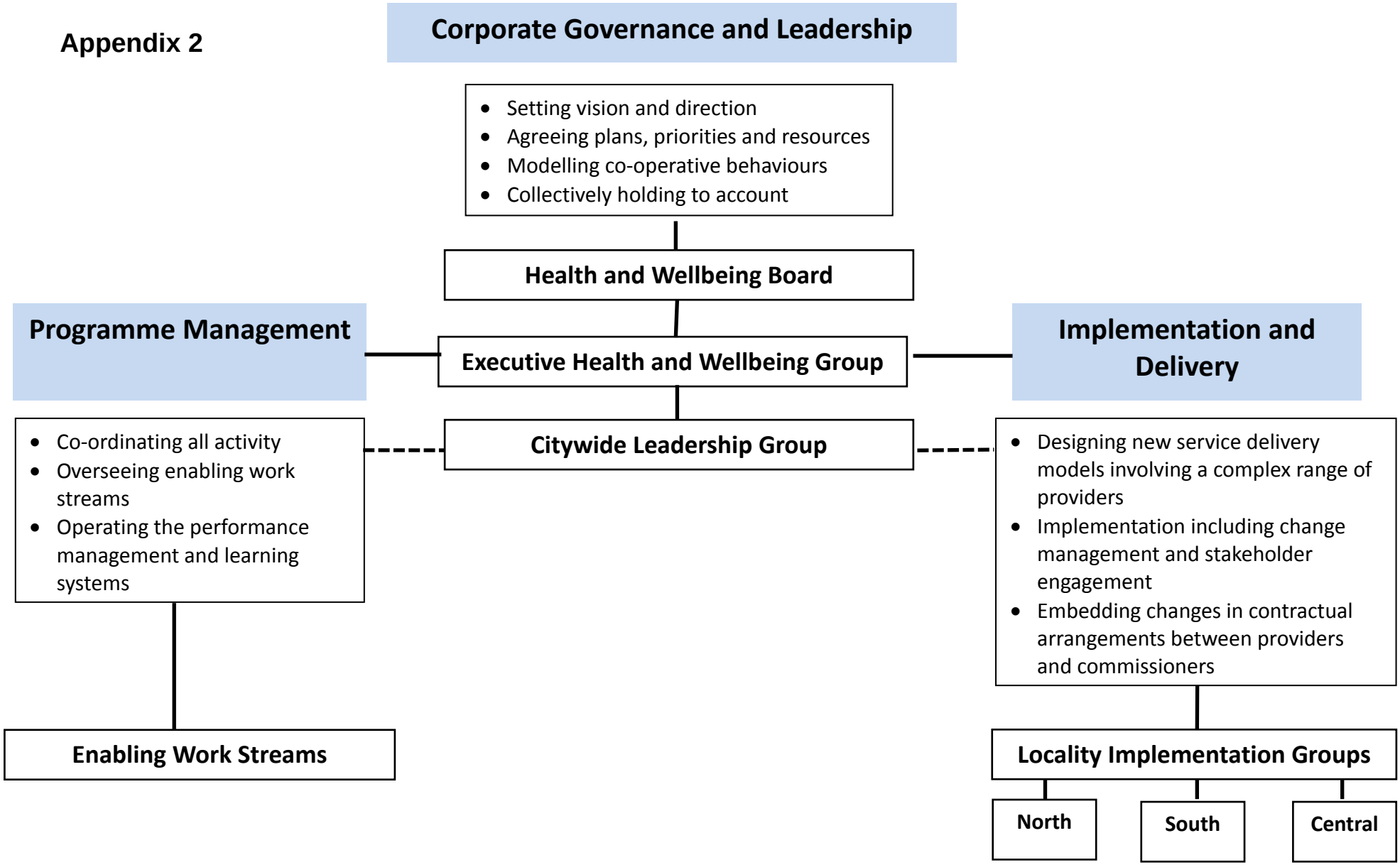
It is essential that all elements of the systems have visibility as to the progress being made in implementing LLLB. This should include both progress against milestones and also progress towards the delivery of intended outcomes. CWLG has previously generated a set of metrics which will evaluate progress on a range of dimensions. The Programme Office will develop this into an operational scorecard for submission on a monthly basis to the CWLG and the EHWG. The Programme Office will also liaise with Locality Implementation Groups to ensure

that progress and performance is being monitored at a locality level on the same basis.

8.6 A Learning Approach

LLLB is an ambitious transformational programme. It requires close cooperation across commissioners and providers, between local government and the NHS, and across differing geographies within the city. It will also entail those working in statutory service delivery to engage in new and different ways with informal carers, patients and citizens. In order to achieve this there will need to be significant changes from the traditional public sector leadership style. It is also the case that many aspects of the programme are breaking new ground. The programme needs to take a learning approach with an emphasis on investing in the development of collaborative leadership skills at every level and the creation of mechanisms for the rapid spread of learning across the city. It is recommended that the CWLG be asked to give further consideration to this and make proposals for the utilisation of an element of the Programme Office funding for investment to deliver it.

Appendix 2


Corporate Governance and Leadership
Setting vision and direction
Agreeing plans, priorities and resources
Modelling co-operative behaviours
Collectively holding to account
Health and Wellbeing Board
Programme Management
Executive Health and Wellbeing Group
Implementation and Delivery
Co-ordinating all activity
Overseeing enabling work streams
Operating the performance management and learning systems
Citywide Leadership Group
Designing new service delivery models involving a complex range of providers
Implementation including change management and stakeholder engagement
Embedding changes in contractual arrangements between providers and commissioners
Enabling Work Streams
Locality Implementation Groups
North
South
Central

Appendix 3

Programme Office Structure

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Note: Strategic Leadership will be provided by the Director of Adults Social Care, providing executive support and linkage between the City Wide Leadership Group, Executive and the Health & Wellbeing Board.

Budgeted Costs 2014/15

The following resources would be funded from the agreed Executive Health and Wellbeing £400K investment fund for the LLLB programme:

Resource Type	Roles	Function	Period	Estimated Cost
Programme Management	1 x FTE Programme Manager (G10)	Manage the strategic programme plan and deliverables supporting the CWLG and supporting an effective learning network for the City.	12 months	£52,579**
Project Management	1 x FTE Project Manager (G9)	Support the professional leads of the enabling domain groups, tracking delivery to agreed plans.	12 months	£49,106
Performance Management	1 x FTE Performance Officer (G8)	Delivery of effective performance reporting for the Programme co-ordinating performance reporting activity across the system, including dashboard reporting for the Health and Wellbeing Board.	12 months	£43,447
Communications and Media	1 x 0.4 Comms Lead (G9) 1 x 0.2 Media officer (G9)	Ensure appropriate communications, engagement and media support is planned and delivered across agreed stakeholder communities.	12 months	c£40K
Programme Support	1 x FTE Project Officer (G6) 1 x FTE Business Support (G3)	Ensure an efficient and effective programme office function is maintained.	12 months	£53,053
Carers Group capacity and involvement	N/A	Contribution to Chief Officer additional time and use of facilities (meeting rooms etc)	12 months	£12K
Customer Engagement	N/A	Customer Engagement events x 3	12 months	£12k
Co-production	0.5 x FTE Project Officer (G6)	Support to establish and implement co-production (1 x FTE additional resource to support working group, plus expense monies to support citizen involvement)	12 months	£25K
			TOTAL	**£287,185**

**** All costs are based on Local Authority posts and grading structures, including 'on costs'**

It is proposed that the remaining balance of funds is reserved for in year investment. Areas which may require further funding include specialist or technical support to the enabling domains for example. Any outstanding balance