Manchester Health and Wellbeing Board
Report for Resolution

Report to: Health and Wellbeing Board – 10 September 2014

Subject: Living Longer Living Better (LLLB) Update

Report of: Citywide Leadership Group (CWLG)

Summary

This update from the LLLB Programme consists of two main items:

1. LLLB Strategic Plan

The Strategic Plan refreshes the strategic vision and objectives of the LLLB Programme in light of progress made over the last 12 months, and presents a delivery plan for 2014-2015, along with an indicative plan for 2016-2020. This Plan builds on previous strategic documentation produced by the Programme, including the Integrated Care Blueprint (March 2013), the Strategic Outline Case (July 2013) and the Strategic Business Case (November 2013) with the intention of superseding them in that it should be regarded as the main reference point for the Programme from now onwards.

2. Better Care Fund Submission

NHS England (NHSE) released refreshed BCF guidance on 25th July 2014, requiring resubmission of revised BCF plans by 19th September 2014. The submission documents are included here for review, and build upon Manchester's previous BCF submission from April 2014.

CWLG members have led efforts within their respective organisations to provide content for the BCF templates, and are confident that the submission documents are a fair reflection of the LLLB Programme in Manchester as it stands currently.

Work will continue on the submission documents up to the deadline date in response to any further support and guidance issued by NHSE. Similarly, any gaps in the documentation as it stands will be filled, for example the completion of Annex 1 and the gaps in provider commentary in section 8 and annex 2. CWLG leads will continue to ensure any changes in content are approved for inclusion by their respective senior management teams.

Recommendations

The Board is asked to:

- Sign off the LLLB Strategic Plan.
- Sign off in principle the BCF documentation.
- Delegate authority to CWLG to sign off the final BCF documentation prior to submission on the 19th September.

Board Priority(s) Addressed:

All

Contact Officers:

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

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, March 2014, May 2014 and July 2014.

Living Longer, Living Better

DRAFT Strategic Plan – Vision for 2020

Version Control

Author: Andrew Southworth, LLLB Programme Manager.

Version	Date	Summary of Changes	Changed by
0.1	10/06/14	First draft for internal use	AS
0.2	18/07/14	Second draft for internal use	AS
0.3	22/07/14	Third draft for internal use	AS
0.4	04/08/14	Final draft for consultation	AS
0.5	22/08/14	Including comments from consultation	AS
1.0	03/09/14	Final draft for HWB	AS

Distribution:

Name	Area of Responsibility
CWLG Members	Quality assurance
HWB Members	Sign off

Approved by:

Name	Area of Responsibility
Sign off recommended from HWB	

CONTENTS

1. Section One - Introduction

1.1 Purpose of Document

The purpose of this document is to refresh the strategic vision and objectives of the LLLB Programme ('the Programme') in light of progress made over the last 12 months, and to present a delivery plan for 2014-2015, along with an indicative plan for 2016-2020. This Plan builds on previous strategic documentation produced by the Programme, including the Integrated Care Blueprint (March 2013), the Strategic Outline Case (July 2013) and the Strategic Business Case (November 2013) and supersedes them in that it should be regarded as the main reference point for the Programme from now onwards.

To date, the Programme has been 'emergent', in that it has evolved over the past year to facilitate better coordination of activity and by doing so has demonstrated the value of a more joined-up citywide approach. Both the vision for LLLB, and the end goal, has been necessarily emergent given the radical changes taking place in both the commissioner and provider operating environments, and the complexity of the wider strategic context in which LLLB is delivering.

This emergent approach has enabled the rapid development of Care Models and New Delivery Models, along with the financial and operational governance processes that support these developments. In effect, the groundwork has been laid to move the Programme from being 'emergent', to being more 'vision-led'. A 'vision-led' programme is characterised by a clearly defined vision, strong programme management and leadership aligned to a defined programme plan, and a focus on the radical transformation of operations. The Strategic Plan enables and solidifies this shift.

The LLLB Programme spans only part of the overall health and social care budget for the city and partner organisations recognise that there is potential for fuller integration. Integration of health and social care services into delivery organisations or vehicles could further support the development and delivery of more effective and efficient services and greatly increase both the scale and pace of delivering the LLLB vision. Running alongside the LLLB Programme, partner organisation have determined that there should be focused joint working to explore what such an integrated development might look like.

The Strategic Plan is a working document, so the intention is to keep it short and focused.

1.2 Content

The Strategic Plan is split into five sections, of which this introduction is section one. Section two will set out the wider strategic context in which the Programme is operating, and will propose a refreshed vision statement and suite of strategic objectives.

Section three will outline progress made over the last year and lessons learned for 2014/15, along with key collaborative and development opportunities to be progressed.

Section four will build on the vision statement and strategic objectives identified in section one, and will outline the approach to planning the Programme, including governance and decision making considerations, the innovation model, and critical success factors for the Programme.

Section five will place section four in the context of 2014-15, and will describe the key workstreams and deliverables for the coming year, along with indicative objectives for future years.

1.3 Ownership and Review Cycle

The Programme has eight core delivery partners:
- Manchester City Council (MCC),
- Manchester Mental Health and Social Care Trust (MMHSCT),
- North Manchester Clinical Commissioning Group (NMCCG),
- Central Manchester CCG (CMCCG),
- South Manchester CCG (SMCCG),
- Pennine Acute Hospital Trust (PAHT),
- Central Manchester Foundation Trust (CMFT),
- University Hospital South Manchester (UHSM).

Each of these partners has a nominated lead for LLLB that sits on a LLLB Citywide Leadership Group (CWLG) that meets weekly. The CWLG has produced this document, and is responsible for delivering the Strategic Plan. CWLG membership at August 2014 can be found in Appendix A. The CWLG will review and refresh this Strategic Plan on a yearly basis, with the updated yearly Plan being presented to the Health and Wellbeing Board for approval. This, in effect, agrees the work plan for the CWLG for the year ahead.

1.4 Guide to Terminology

The table below is a guide to common terminology used throughout the Strategic Plan.

Term Used	Explanation
Locality System	Used throughout this document to cover the health and social care services delivered in one of Manchester's three defined geographical and/or organisational boundaries: North Manchester, Central Manchester and South Manchester.
Cohort	A grouping of people with similar needs in common, for example 'adults at the end of life'.
Care Model	A document that identifies the commissioning outcomes and standards for each cohort agreed collectively by the three Manchester Clinical Commissioning Groups (North, Central and South) and Manchester City Council. It

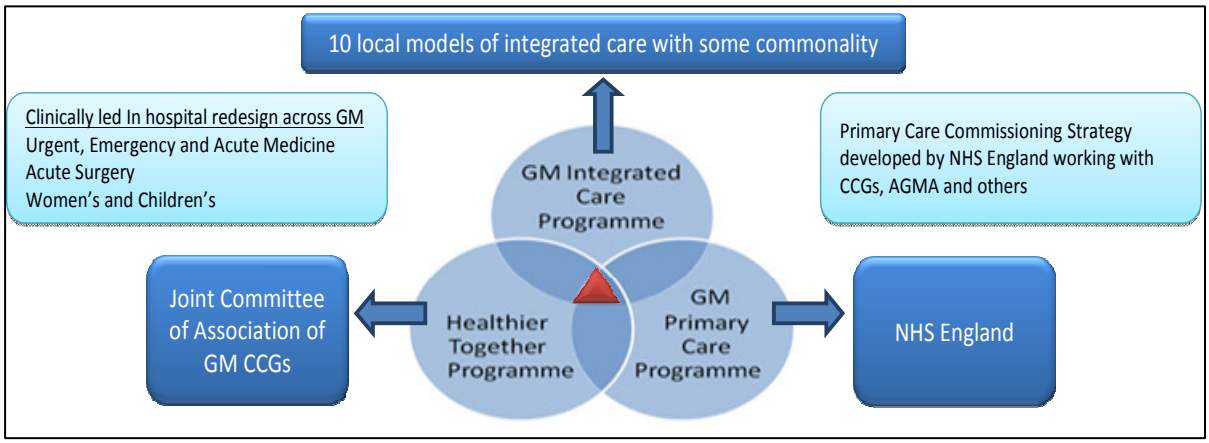
	identifies what 'success' look like for the cohort, and defines the outcomes commissioners expect.
New Delivery Model (NDM)	A document developed on a locality basis which identifies how the locality will change the way it delivers services to a defined cohort to meet the outcomes and standards determined in the cohort's Care Model.
City Wide Framework	An agreement between partners to develop a service framework that spans the city, rather than a single locality, in order to meet the outcomes and standards determined in the cohort's Care Model.
Business Case	A document where a case for funding is made for an initiative that will contribute to a NDM.
Better Care Fund & Local Development Fund	The budget through which initiatives identified by business cases are funded. The Better Care Fund is the terminology adopted by Government. The Local Development Fund is the label Manchester has given to the Better Care Fund.
Community Based Care System	The system LLLB is looking to develop to enable activity and funding to be shifted from the in-hospital system.

2. Section Two – Strategic Context

2.1 Overview

The strategic environment of which LLLB is a part is complex. It will constantly shift and change as decisions on organisational priorities and funding are periodically reviewed, and as feedback from staff and citizens on the new services being delivered is incorporated into future programme planning and design. The current strategic environment is presented in outline in this section.

At a **Greater Manchester** level, the overarching strategic lead stems from the Public Sector Reform Programme, which encompasses Complex Dependency and Health and Social Care Integration. Health and Social Care Integration is split into three interrelated programmes, set out below:



Both the Integrated Care Programme and the Primary Care Programme are seeking to transform out-of-hospital health and social care services, and although they operate across Greater Manchester, delivery will take place in each Local Authority and CCG area. The Healthier Together Programme is a Greater Manchester programme which will transform in-hospital services.

At a **Manchester** level, LLLB is the city's integrated care programme. Strategically, it takes its lead from the Greater Manchester context, above, and Manchester's Health and Wellbeing Strategy, as determined by the Manchester Health and Wellbeing Board. The LLLB Programme is a citywide programme which will develop and lead the framework for integrated care and service transformation; delivery will take place in the three locality systems. LLLB will also align closely to programmes to develop and transform Primary Care being led and implemented in the three CCG local areas.

There are a number of other health and social care programmes that will impact upon, and will be impacted by, LLLB, including (but not exclusively):

- Manchester Mental Health Improvement Programme,
- Macmillan Cancer Improvement Partnership,
- Wellbeing and Lifestyle Services Redesign Programme,
- Reducing Social Isolation Grants Programme,
- Complex Dependency Programme.

Similarly, there are a number of Manchester wide strategies that are being developed and delivered over the course of 2014/15 that LLLB will need to both feed into and be informed by. In particular the Manchester Strategy, a 10 year strategy for the city, is being developed to replace the Community Strategy. The development of this strategy is being overseen by the newly established Manchester Leaders Forum, which includes three senior leaders from the Manchester Health and Wellbeing Board. Other important strategies include the Manchester Carer's Strategy, All Age Disability Strategy and Housing for an Age Friendly Manchester, amongst others.

Wider city and regional strategies that are not solely concerned with public sector reform and health and social care are also part of the strategic environment and need to be taken account of when aligning objectives and timescales.

It is the view of the CWLG that the Manchester Health and Wellbeing Strategy is the preeminent health and social care system strategy in Manchester from which all the delivery programmes should take their direction. This strategy is scheduled to be refreshed by April 2015, and should inform, and be informed by, this Strategic Plan.

2.2 Drivers

The LLLB Programme is looking to contribute to efforts underway across the city to tackle the four main issues acting upon the health and social care system, namely:

- Consistently poor health outcomes for Manchester residents,
- Inconsistent services in terms of access and quality,
- Increases in demand across in-hospital and out-of-hospital services,
- Financial pressures.

The detail behind these issues will not be repeated in this Plan as they are covered in depth in the Manchester Health and Wellbeing Strategy. However, it is worth noting here that the financial pressures in particular are stark. A combined financial pressure of circa £250m has been identified across the three main acute providers, the three CCGs, and MCC. The LLLB Programme, along with the Healthier Together and Primary Care programmes are expected to make a significant contribution to alleviating these financial pressures.

2.3 Connections

The complexity of the public sector reform environment described in section 2.1 requires the range of delivery programmes working within the health and social care environment to work in harmony. This presents challenges and opportunities around the following:

- Alignment of programme aims, objectives and timescales, particularly where programme activity is enabling other activities in related programmes.
- Different programmes working with the same citizen cohorts, which could lead to confusion and duplication, or collaboration and innovation depending on the effectiveness of programme leadership and governance.
- Contribution to financial outcomes, particularly in terms of having a defined programme contribution, a robust and transparent mechanism to calculate this

contribution, and an agreed process between related programmes for rescoping financial contributions in response to changes in the strategic environment.
- Governance arrangements, particularly in terms of understanding 'where the buck stops' and ensuring organisations are spreading the programme governance load as evenly as possible amongst their senior leadership teams to mitigate against change fatigue.

The CWLG is committed to working with other programme leadership teams over the following 12 months to better align aims, objectives and outcomes to mitigate against the challenges identified above, and take advantage of the opportunities for inter-programme collaboration that present themselves.

2.4 LLLB Vision Statement

The LLLB Programme has outlined a number of strategic statements, aims and objectives in documentation produced for the Health and Wellbeing Board over the last year, whilst the timescale for the delivery of the programme has fluctuated between 5 and 10 years.

The vision statement presented below is indented to be unambiguous, and encapsulates the scale of the challenge ahead, whilst acting as a focus for the enthusiasm and activity of all partners involved in LLLB.

"By 2020, the LLLB Programme will have radically transformed Manchester's community based care system. This transformation will support people to live longer, healthier lives by ensuring a wide range of high quality health and social care services are easily accessible within communities, and are centred on the individual and their specific health needs."

2.5 LLLB Strategic Objectives

The following strategic objectives will be pursued up to and beyond 2020 by all partners involved in the LLLB Programme, to deliver the vision:

IMPROVING HEALTH OUTCOMES - Contribute to an improvement in key quality of life and life expectancy outcomes in Manchester by driving improvements in the community based care system, ensuring a range of new, innovative place-based services are centred on the individual.

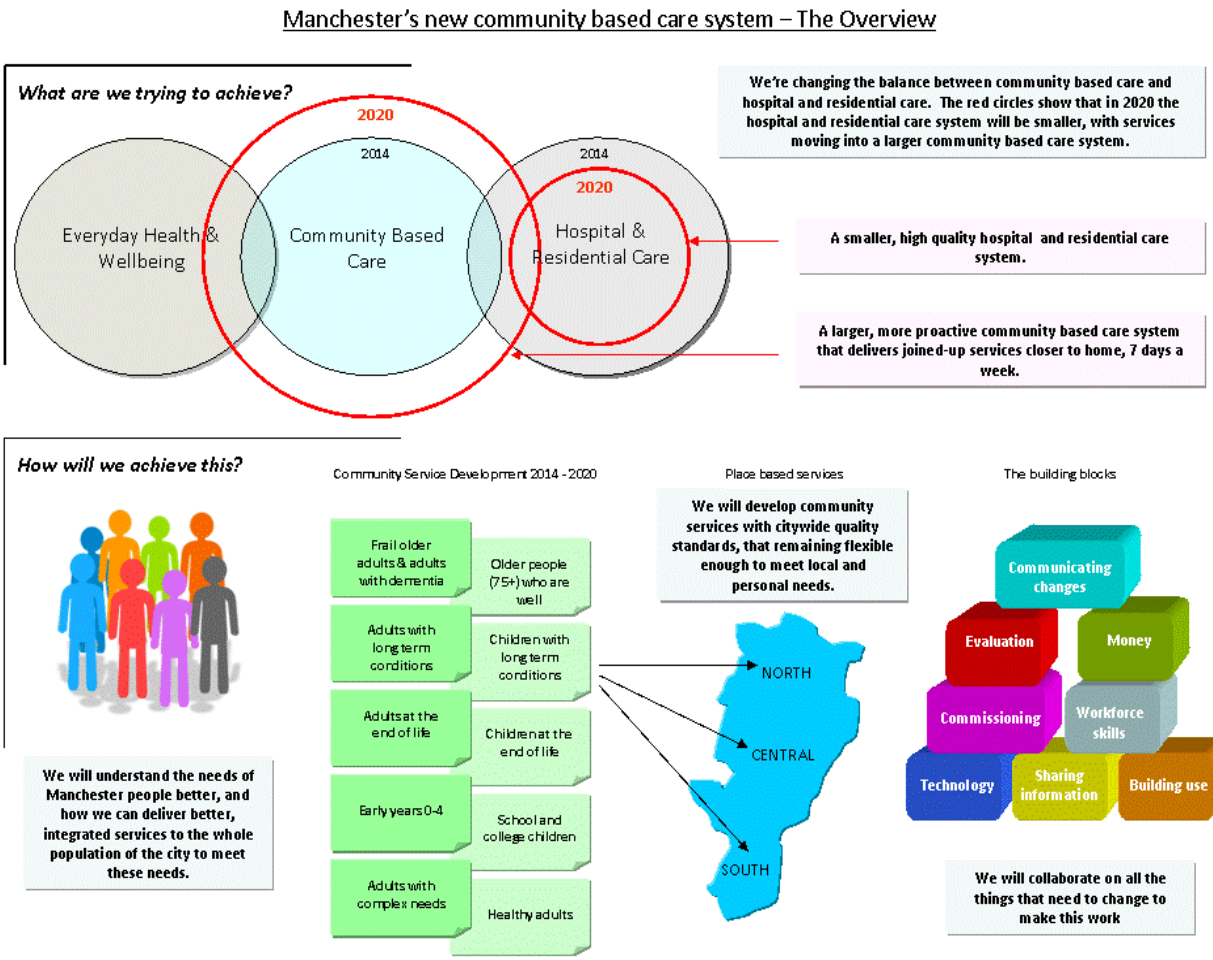
IMPROVING SERVICE STANDARDS - Ensure that the new community based care system delivers high quality, easily accessible services regardless of where in Manchester an individual lives.

FINANCIAL SUSTAINABILITY - Deliver a financially sustainable community based care system for Manchester that enables a safe reduction in the overall spend on health and social care services and a rebalancing of resources from in-hospital to community based care.

SUPPORTING SELF RELIANCE - Increase the volume, range and effectiveness of prevention and early intervention services available, including a wider choice of resident self-care options, to enable people to maintain their independence within a strong community support network.

The strategic objectives are underpinned by a variety of key performance indicators, which will be reported against on a regular basis – see Section Five for further details on performance measurement and evaluation. Progress towards the strategic objectives will be reviewed annually as part of the mid-year Strategic Plan review, starting in June 2015.

The infographic below visually illustrates the Programme:



2.6 Beyond 2020

It is important to note here that integration, and the development of community based care, will not automatically halt in 2020. The 2020 target should be seen more in terms of creating a community based care system that helps achieve a financially sustainable health and social care system, enabling the estimated 20% shift of activity from in-hospital to community services. The continued development of a community based care system itself will be an ongoing process.

3. Section Three – Progress in 2013/14

3.1 Overview

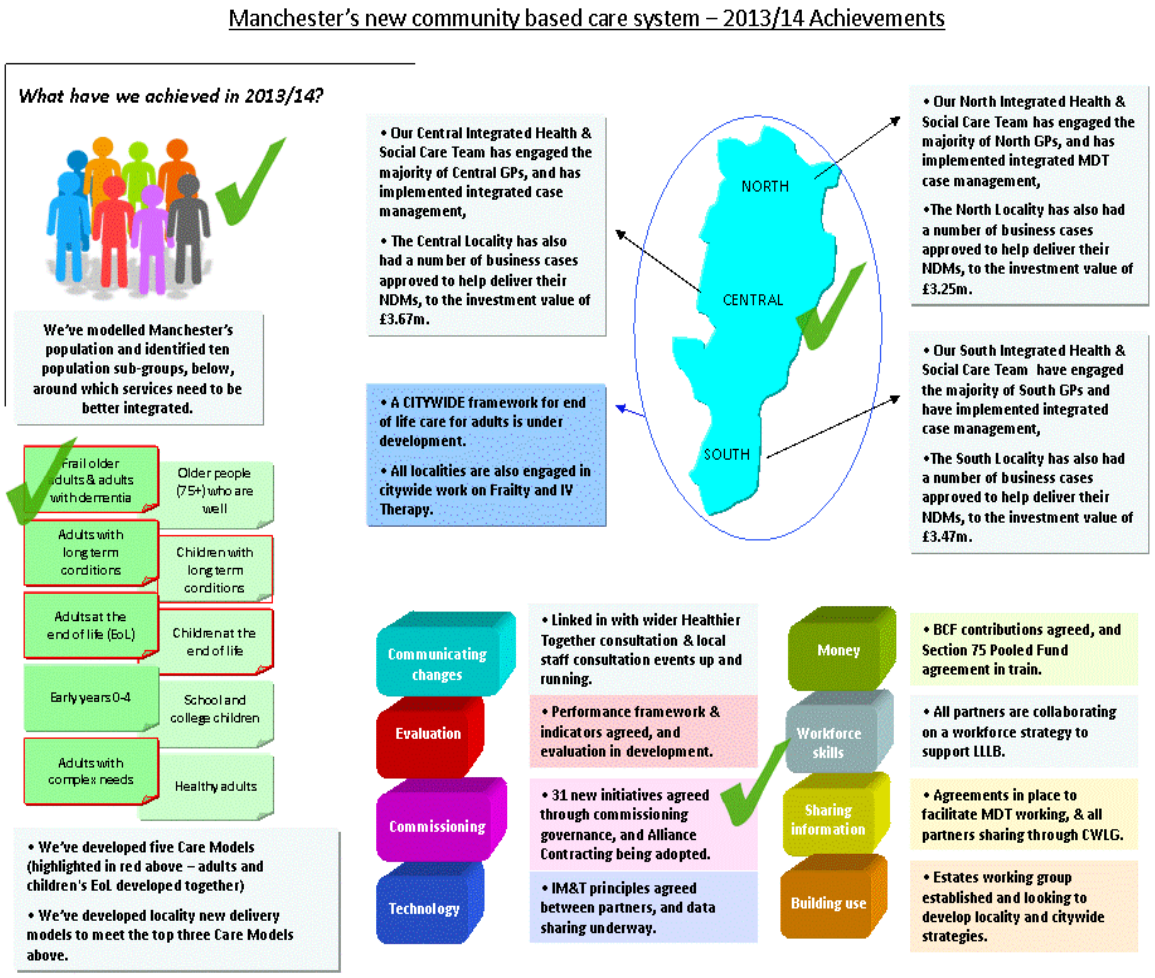
The progress of the Programme since the development of the Integrated Care Blueprint in March 2013 has been reported to the Health and Wellbeing Board at two month intervals. Given this, the information below is a brief summary of the main achievements to date, and outlines what the CWLG has learned along the way to inform the programme for 2014/15.

3.2 Key Successes

- Delivery of an Integrated Care Blueprint in March 2013, which all core partners have identified as a huge step on the road to meaningful collaboration. The strategic statements identified in the Blueprint have underpinned the programme for the last 12 months.
- Production of the Strategic Outline Case (July 2013) and Strategic Business Case (November 2013). Both these documents resulted from the core partners working together to model the population, identify priority sub groups and prioritise Care Models for development.
- Strengthening of the Programme governance structures, including the establishment of the LLLB Reference Group to increase specialist advisory capacity to the CWLG to ensure that the programme planning, design and implementation is sound; and the LLLB Co-Production Group to ensure that people who use services, their families and carers have a chance to help design the changes.
- Five citywide Care Models prioritised and developed: adults and children at the end of life; adults with long term conditions; children with long term conditions; frail older adults and adults with dementia; and adults with complex needs.
- New Delivery Models (NDM) developed in each of the three locality systems to meet the outcomes identified in the Care Models.
- The three Integrated Multi-Disciplinary Delivery Models in each of the three locality systems have successfully joined up with the vast majority of GP practices in the city to deliver coordinated health and social care services in the community. All three Models are due to be mainstreamed in the latter half of 2014.
- Agreement on financial contributions to a Local Development Fund, providing the start up capital for the development and implementation of locality NDMs to meet the objectives of the Care Models.
- Business cases approved with a total investment value of £10.4m for initiatives that form part of NDMs, drawing down funding from the Local Development Fund, with all initiatives due to go live by 30th June 2014.
- Well received bid to draw down funding from the government's Better Care Fund (BCF) for 2014/15.
- Agreement between core partners to safeguard future investment in collaborative working by establishing a Pooled Fund through a Section 75 agreement.

- As a result of the above, the alliance between the core partners has been strengthened, which bodes well for the success of the Programme.

The infographic below illustrates the development of the Programme, and successes to date:



3.3 Things to Focus on in 2014/15

Having reviewed the progress made over the previous 12 months, the CWLG has identified the following areas of the programme in which improvements need to be prioritised. These improvements feed into the activity planning in sections four and five.

3.3.1 Collaboration

- Develop the remaining Care Models

Of the five prioritised Care Models, the Adults with Complex Needs and Children with Long Term Conditions Care Models need to be developed further in 2014. The remaining Care Models will then be prioritised for development over the course of 2014-2015.

- Make better use of the expertise of partners in the community based care system

In particular, the LLLB Reference Group needs to be refreshed to align with the 2014/15 Programme.

- Don't be isolated, work better with other programmes, organisations and initiatives

Better working links need to be forged with the programmes identified in section one of this report, along with redesign work taking place in parallel to LLLB. A good example of this is the work being led at present by MCC to redesign and produce a new specification for Wellbeing and Lifestyle Services following the transfer of public health commissioning responsibilities to local government.

Similarly, the Programme will strive to enhance links with the community sector through the LLLB Reference and Co-Production Groups, and understand better where the needs of the service users represented by organisations on these groups can be addressed in design work. A good example of this is the support that needs to be provided for carers, given they will play an important role in the new community based care system. The implications are both financial (continued support for unpaid carers for example, in the face of shrinking local authority social care budgets) and operational (ensuring the caring role is recognised and catered for in workforce planning, for example).

3.3.2 Programme Development & Leadership

- The CWLG needs to add challenge into the business case process, to ensure NDM development matches need

The CWLG is responsible for taking a citywide viewpoint, and as a result must act as a catalyst for system innovation. To enable this, the CWLG will look to improve the business case development and approval process for drawing down funding.

- Further develop and refine performance and evaluation systems and process

In particular, top-down and bottom up indicators need to be aligned, and the challenge into the system offered by CWLG (bullet point above) needs to be evidence based. Performance and evaluation systems also need to help develop a 'learning system' across the city, where best practice is formally sought and shared.

- Support a move to 'place based' services

As the Programme develops, the ties that bind organisations to their own geographically defined boundaries need to be loosened, so services can truly be integrated across organisation boundaries and designed and delivered to directly meet customer needs.

- Develop a more structured programme

To support the shift from an 'emergent' programme to a 'vision led' programme, the CWLG will strengthen its programme management capabilities – see sections four and five for more detail.

4. Section Four – Plan for 2020

4.1 Outline of Approach

The operating environment in which the LLLB Programme sits is complex and dynamic, as outlined in section two. Aside from complexity engendered by the number and variety of organisations involved in making LLLB happen, the political, legal and economic landscape is changing at a rapid pace, driven by recent and new legislation (Health & Social Care Act 2012, Care Act 2014), and an impending General Election. The Programme itself requires a big shift in the way society understands and interacts with health and care services to be successful. The role technology will play in a future community based healthcare system is also set to increase.

Given this complexity, the ability of the partners involved in LLLB to accurately plan a programme in detail up to 2020 is limited. Deliverables and milestones will be set for the twelve month period covered by this Plan, along with medium and long term deliverables set based on the condition of the operating environment at the time of writing (see section five). These medium and long term deliverables will reviewed on an annual basis, enabling the programme to adapt as the factors mentioned in the paragraph above continue to shape the health and social care system.

Similarly, this level of environmental complexity and dynamism also means that a definitive model of the 2020 community based care system cannot be designed at this stage, and would be misleading if this were to be attempted. The Programme has previously developed a vision for future services using the 'Mrs Pankhurst' construct (see appendix B), which gives an indication of how service users will experience the new community based care system. This work provides a starting point to begin to design the outline of 2020 community based care system in more detail; a Programme priority over 2014/15.

Over the next year programme leadership will also continue to focus on creating the conditions within which innovation can flourish, and putting the building blocks in place to enable this. These building blocks are identified in 5.2.

The innovation model used by the Programme to develop new services is set out in 4.2, below. This model will continue to be used over the course of 2014/15, and will be reviewed for effectiveness as part of the refresh of this Plan in 2015. Crucially, this model has buy-in from all the partners involved in the Programme, and the Care Models in particular are recognised as being key strategic documents that link the aims and ambitions of all partners.

The focus over the 2013/14 has been very much on:

- Prioritising and developing Care Models based on population coverage and cost. For example, the five sub-groups identified as the highest priority (see the model in 3.2) make up only 18% of the population yet 67% of the cost.
- Developing NDMs to deliver against the Care Models by sustaining existing initiatives and pilots, and initiating new innovative services,

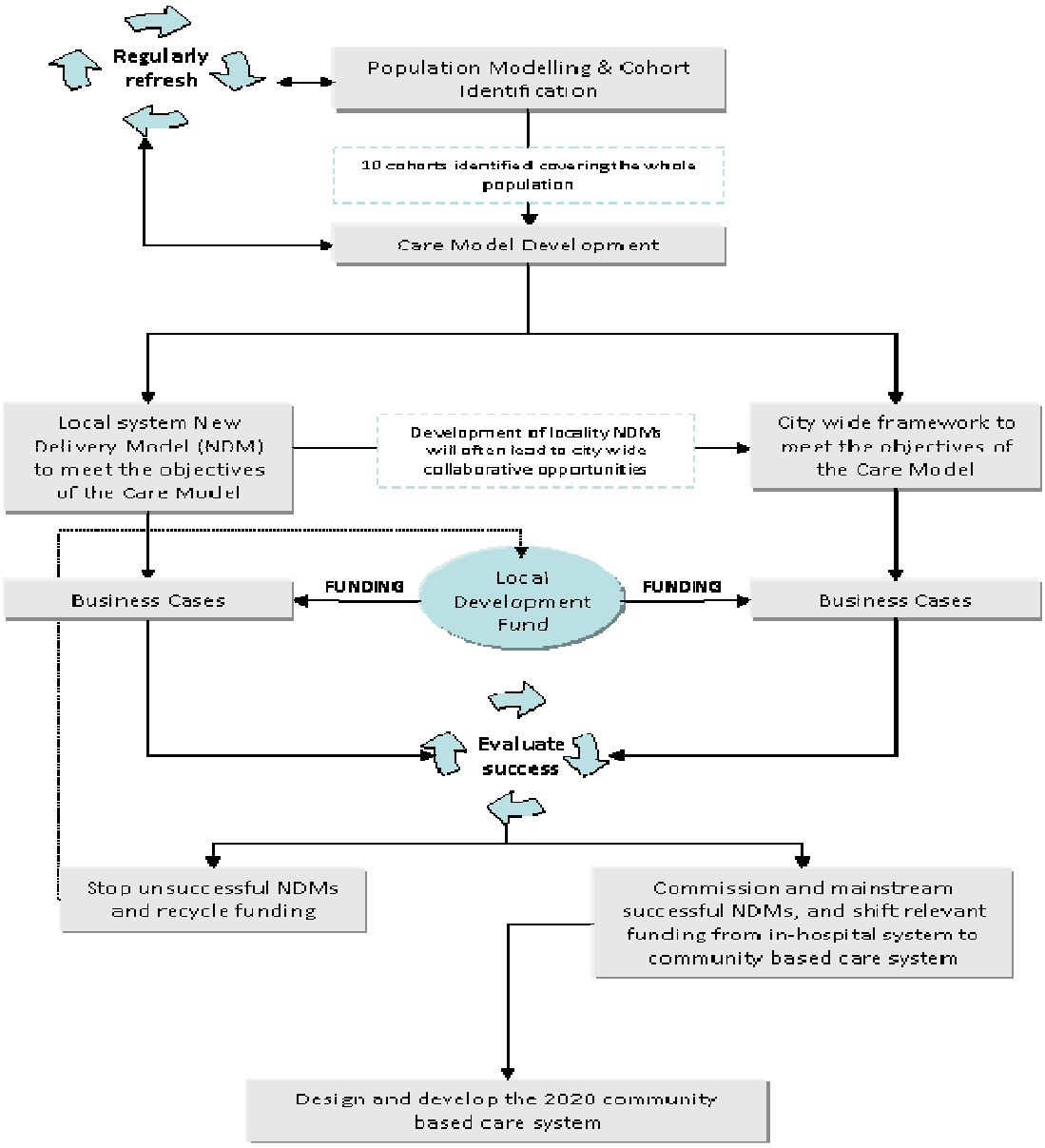
- Allocating Better Care Funding (BCF)/Local Development Funding (LDF) to support these new delivery models.

The focus for 2014/15 needs to shift onto four key priorities:

- Development of a performance and evaluation framework that drives decision making on new delivery model investments (which services need to stop and which services need to start). An enhanced ability to track and manage the impact of investments on service cost and service user outcomes will enable BCF/LDF money to be recycled and successful initiatives to be mainstreamed,
- Allied to the above, financial processes need to be further developed to sustain funding for innovation whilst determining the impact upon savings targets and the shift needed from in-hospital to community budgets,
- Development of remaining Care Models and related NDMs,
- Taking a system-wide approach to design, alongside the cohort approach currently being pursued. This requires two interrelated tasks: to better understand the services available in the community at present, and the impact they have on people's health and wellbeing; and to take this learning along with learning from the successful new delivery models and aggregate it all up into a design for the 2020 community based care system.

These four priorities are reflected in the 2014/15 deliverables set out in section five.

4.2 The LLLB Innovation Model

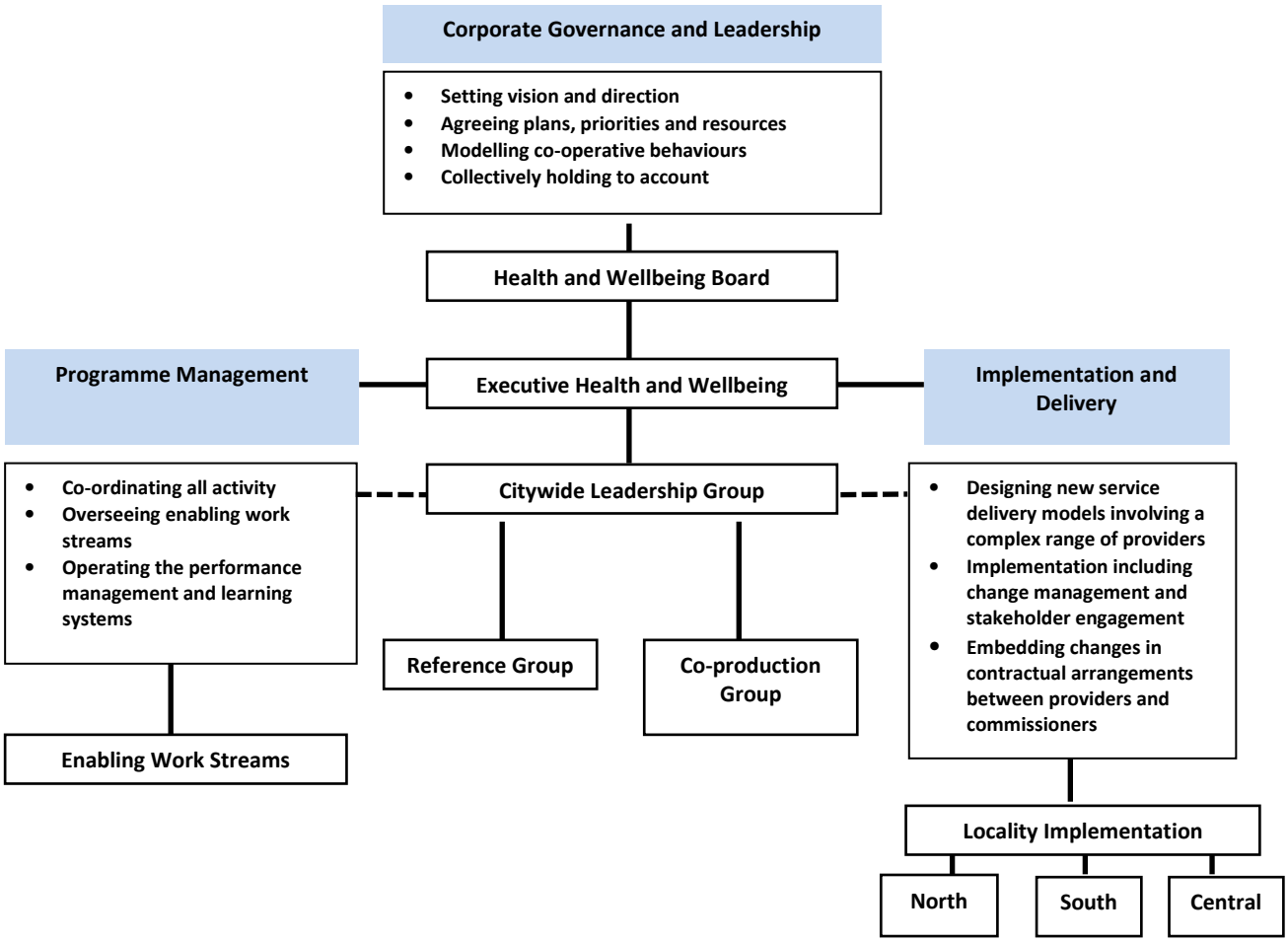


4.3 Decision Making & Governance

One of the key leadership challenges in the Programme is to secure agreement amongst partners and stakeholders to make decisions about the future community based care system on a citywide basis, and to develop formal governance structures that facilitate this. The CWLG is one such governance forum.

However, the related challenge is to continue to recognise the value and necessity of locality decision making structures. Commissioners still have to coordinate existing contracts and payment mechanisms alongside the development of NDMs, and continue to carry the risk related to these existing arrangements. All locality systems have different starting points related to the make up of hospital and community services, and all operate over different geographical boundaries. The CWLG will continue to work to ensure local governance works in harmony with citywide

governance. The following governance diagram was presented to the HWBB in early 2014, and still provides a good high level overview of Programme governance:



4.4 Making the LLLB Programme Work

4.4.1 Critical Success Factors

The CWLG has identified ten 'critical success factors' (CSF) that will play an important part in the realisation of the vision for the LLLB programme:

- A strong alliance of commissioners and providers,
- Inspiring leadership,
- Citizens engaging differently with health and care services,
- A workforce that works differently to support the new community based care system,
- An environment that supports innovation,
- An infrastructure that supports innovation,

- A system that learns from the past to inform the future,
- Place based services built around the person,
- Effective programme management,
- Effective links between programmes.

These CSFs underpin LLLB, and are applicable across all the whole programme of work.

4.4.2 Risk and Issue Management

The LLLB Programme Office holds a live risk log and the CWLG reviews and manages risks and issues on a regular basis. The current risk log is included at appendix C.

5. Section Five – Delivery Plans

5.1 Context

To recap, 4.1 identified that the complexity of the operating environment LLLB is working within affects the planning horizon. Objectives and deliverables can be planned in some detail over the short term (12 months), and naturally become more difficult to plan accurately beyond that timescale. It also needs to be recognised that the Programme is dynamic, and investments made in new delivery models in 2014/15, and the subsequent success or failure of these models, will require the Programme to be regularly updated and refreshed.

Also outlined in 4.1 is the shift in focus for the Programme in 2014/15 onto four key priorities, which are reflected in the deliverables identified in this section.

5.2 Workstreams/Domains

The Programme has been running a number 'Domains' over 2013 and into 2014, some throughout that period, some time-limited. Domains included 'Our population', 'Our Workforce', Our Information', 'Our Buildings', 'Our Money', 'Performance and Evaluation' and 'Engagement for Social Change'.

In these cases, a domain is a workstream of the programme, designed to allow partners to collaborate on programme themes in which all partners believe a joint approach is critical. At the time of writing most of the domains are in abeyance pending two things:

- Securing the right domain leadership – The CWLG has learned that domains work best when a specialist in the domain field leads the work. CWLG is working to identify the right specialist leadership for each domain.
- Guidance on objectives and outcomes – The CWLG also learned that domain work has to be focused, with clear objectives and milestones, to make collaboration work. Domains also need to be prioritised, as some will require an up front investment of time and resources in year one and two of the Programme, whilst some will become more resource intensive in later years.

In some cases work identified by the domains as being 'critical' is still being taken forward, with weakened ties to LLLB. This, in itself, presents risks around coordination and effectiveness, and will be remedied by this Plan.

CWLG has also learned that some of domains need collaboration on a greater scale, for example at a cross-programme level or a Greater Manchester (GM) rather than Manchester level, to achieve the greatest benefit. CWLG will look to work with programme and GM partners over the period covered by this Plan to enable this.

For 2014/15, the Programme breaks down into the following workstreams/domains, within which deliverables have been identified:

- **System Innovation**

Including the development of Care Models and New Delivery Models, the design of the community based care system, and continued research and intelligence work related to population modelling.

- **Infrastructure**

Including three workstreams: Information Management & Technology (IMT); Estates; and Workforce. These workstreams are grouped together because they are dependant on the evolving design of the new community based care system to determine the parameters in which they operate. Their scope will also need to be expanded to take account of related programmes and strategies at both a city and regional level, and the need for consistency across the wider range of delivery partners and stakeholders across the city. For example, the role of the carer forms part of the workforce development challenge.

- **Performance Monitoring and Evaluation**

Including the development and operation of a performance and evaluation framework. This framework will link system wide indicators with the evaluation of Local Development Fund investments.

- **Commissioning Innovation**

Including the further development of innovative contracting arrangements, Alliance Contracting for example, and the commissioning decisions related to the evaluation of LDF investments.

- **Financial Innovation**

Including the development of a Section 75 agreement to pool funds into the LDF, the further refinement of financial targets for health and social care and the development of processes to support the flow of money, realisation of savings and shift of budgets required by LLLB.

- **Leadership**

Including the strengthening of the strategic coalition of partners, development of governance arrangements to make the most of wider expertise residing in the Reference and Co-Production Groups, and forging stronger strategic and delivery links with related programmes.

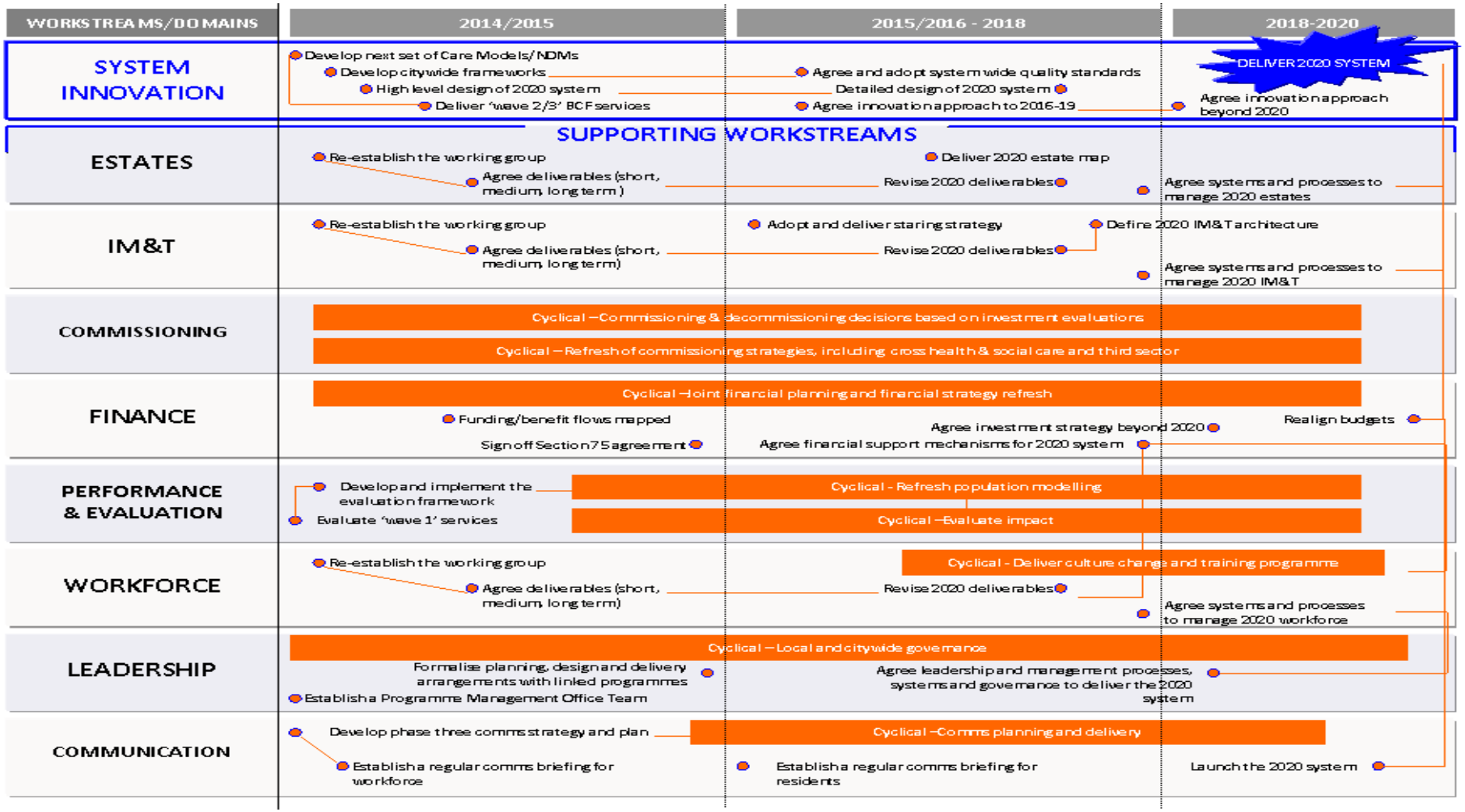
- **Communications**

Including the further development and delivery of the LLLB communications strategy and plan, and the forging of stronger communication links between related programmes. The outcomes of the ongoing public consultation being delivered through the Healthier Together Programme will also inform the LLLB communication strategy.

All the priority areas above will be supported by a Programme Management Office following best practice programme management principles.

5.3 Programme Deliverables

The programme deliverables have been mapped out in detail, and are tracked weekly at CWLG using a programme plan. The diagram below illustrates the direction of travel for the programme, and maps high level deliverables over the short, medium and long term, by workstream.

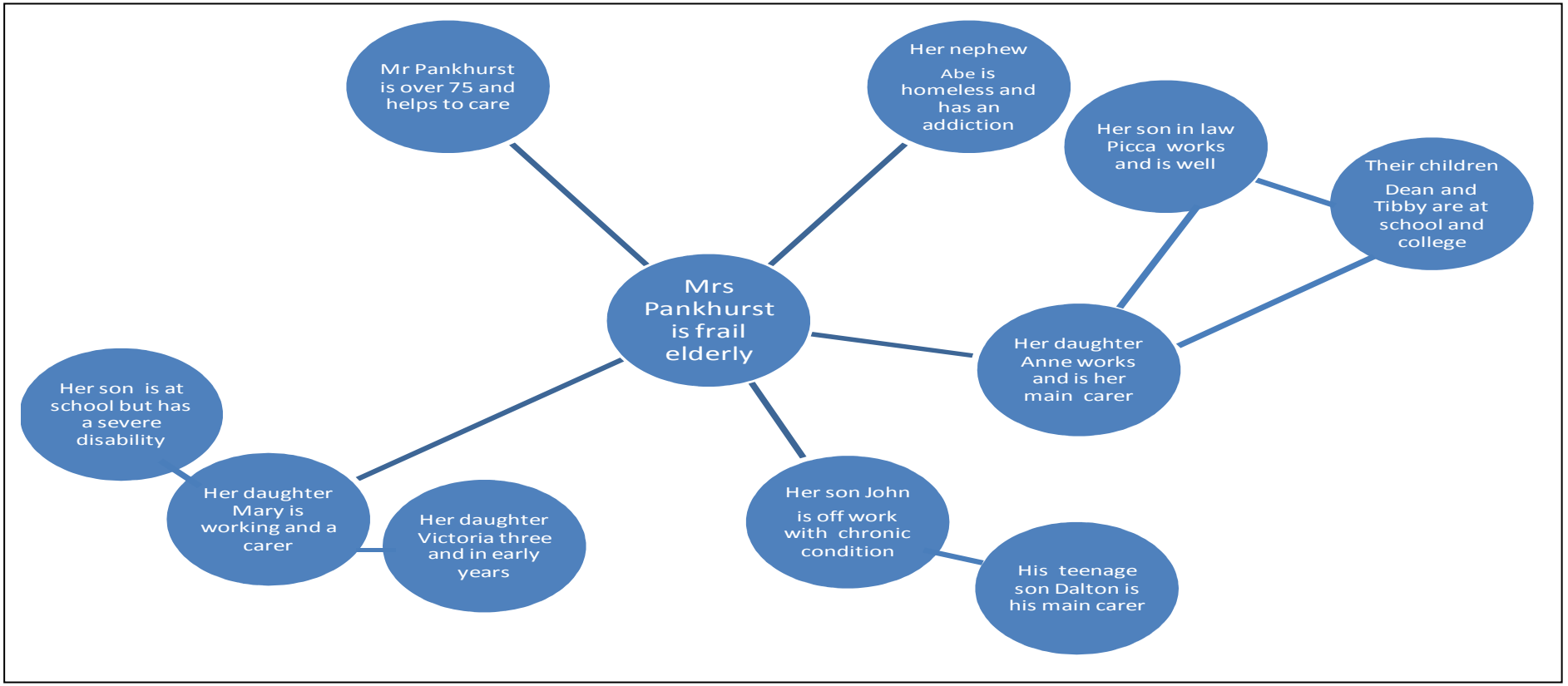

WORKSTREAMS/DOMAINS
2014/2015
2015/2016 - 2018
2018-2020
SYSTEM INNOVATION
Develop next set of Care Models/NDMs
Develop citywide frameworks
High level design of 2020 system
Deliver 'wave 2/3' BCF services
Agree and adopt system wide quality standards
Detailed design of 2020 system
Agree innovation approach to 2016-19
DELIVER 2020 SYSTEM
Agree innovation approach beyond 2020
SUPPORTING WORKSTREAMS
ESTATES
Re-establish the working group
Agree deliverables (short, medium, long term)
Deliver 2020 estate map
Revise 2020 deliverables
Agree systems and processes to manage 2020 estates
IM&T
Re-establish the working group
Agree deliverables (short, medium, long term)
Adopt and deliver staring strategy
Revise 2020 deliverables
Define 2020 IM&T architecture
Agree systems and processes to manage 2020 IM&T
COMMISSIONING
Cyclical – Commissioning & decommissioning decisions based on investment evaluations
Cyclical – Refresh of commissioning strategies, including cross health & social care and third sector
FINANCE
Cyclical – Joint financial planning and financial strategy refresh
Funding/benefit flows mapped
Sign off Section 75 agreement
Agree investment strategy beyond 2020
Agree financial support mechanisms for 2020 system
Realign budgets
PERFORMANCE & EVALUATION
Develop and implement the evaluation framework
Evaluate 'wave 1' services
Cyclical - Refresh population modelling
Cyclical – Evaluate impact
WORKFORCE
Re-establish the working group
Agree deliverables (short, medium, long term)
Cyclical - Deliver culture change and training programme
Revise 2020 deliverables
Agree systems and processes to manage 2020 workforce
LEADERSHIP
Cyclical – Local and citywide governance
Formalise planning, design and delivery arrangements with linked programmes
Establish a Programme Management Office Team
Agree leadership and management processes, systems and governance to deliver the 2020 system
COMMUNICATION
Develop phase three comms strategy and plan
Establish a regular comms briefing for workforce
Cyclical – Comms planning and delivery
Establish a regular comms briefing for residents
Launch the 2020 system

Appendix A – CWLG Membership and Contributors

The CWLG is made up of representatives from the eight partners (lead representatives in bold below) , and is supported by a wider group of specialists. The table below represents the contributors to this Plan, affiliated to the CWLG.

Name	Organisation	Role
Mike Houghton-Evans	**Strategic Lead for LLLB**	**Strategic Director Adults Services, MCC**
Deborah Lyon	**Pennine Acute Hospital Trust**	**Head of Service Transformation - Community and Social Care**
Helen Speed	**North Manchester CCG**	**Programme Director, Urgent Care and Collaborative Commissioning**
Sara Radcliffe	**Central Manchester Foundation Trust**	**Director of Integrated Care Strategy**
Ed Dyson	**Central Manchester CCG**	**Assistant Chief Officer**
Tony Ullman	Central Manchester CCG	Head of Commissioning and Quality
Peter Connolly	**University Hospital South Manchester**	**Interim Associate Director for Integration**
Claudette Elliott	**South Manchester CCG**	**Deputy Chief Officer**
John Harrop	**Manchester Mental Health and Social Care Trust**	**Director of Strategy, Transformation and Performance**
Maeve Boyle	Manchester Mental Health and Social Care Trust	Strategic Programmes Manager
Joanne Royle	**Manchester City Council**	**Strategic Lead for Health Integration**
Nicky Parker	Manchester City Council	Head of Business Delivery
Sam Bradbury	City Wide CCG	Deputy Director
Nick Gomm	City Wide CCG	Head of Corporate Services
Vicky Bottomley	Manchester City Council	Communications Business Lead
Joanne Downs	North Manchester CCG	Head of Finance/LLLB CCG Finance Lead
Rachel Rosewell	Manchester City Council	Head of Finance, Children & Families
Neil Bendel	Manchester City Council	Head of Health Intelligence
David Regan	Manchester City Council	Director of Public Health
Andrew Southworth	Hosted by Manchester City Council	LLLB Programme Manager

Appendix B – What 2020 Looks Like for the Pankhurst Family



The future: 2020

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

- Mrs Pankhurst feels cared for; she is treated with dignity and given information and care to meet her personal concerns and goals which will include decreasing her pain, increasing her comfort and environment at home and giving her support and choice about how to live the remainder of her life with dignity.
- Mrs Pankhurst's daughter Anne will be offered co-ordinated support and information to enable her not only to care for her mother appropriately but to carry on working and caring for the rest of her family including her school aged children. Anne feels well and able to cope.
- Anne's children are knowledgeable about their life styles and their life choices and inspired to live healthy and productive lives. They use technology and services in the community appropriately to self-manage any short-term illness and are aware of risks of accidents and illness through addiction. They have first aid skills to manage most minor injuries.
- Picca is working within one of the new delivery models in the city and is an advocate for caring differently and being able to inspire people to live more healthily, he is volunteering at a local sports centre to coach a youth team.
- Mr Pankhurst has regular screening and health checks. He is supported to enable him to remain well and living independently in the community. He is sharing "Mrs Pankhurst's" care with Anne and is involved in her future care planning.
- John is at work and self-managing his long-term conditions of Chronic Obstructive Pulmonary Disease and diabetes. He has a clear and owned care plan and has learnt how to use technology to enable him to manage his condition with knowledge. He has information about the new delivery model, and feels that, when he needs it, it is responsive to his needs with regular checks and care planning.
- Dalton, his son, is no longer losing days at school in order to care for John and is able to have time to do his homework and socialise with friends. He is now projected to achieve good grades in his GCSEs.
- Mary is able to work and care for both her children, Victoria has had a coordinated programme of screening, immunisation and care in her early years and is now ready for school with the potential to do well. Her son has a shared care plan that Mary understands and a coordinated package which enables him to attend school and be cared for at home when he needs extra support.
- Abe is now in accommodation and has been supported to get a part time job; his health has improved through a coordinated package of care. He is knowledgeable about where to go and how to manage his addiction and illnesses when necessary.

Appendix C – Risk Log as at August 2014

Risk Description	Existing Controls	Likelihood	Impact	Risk Score (L x I)	Response Actions (Mitigation)
The development of our business case for LLLB sits within the context of three overlapping and dependent programmes of work at a Greater Manchester level – 1) LLLB as part of the GM integrated care programme 2) Healthier Together the GM hospital services programme and 3) Primary Care development programme from NHS England. There is a risk that these three programmes are seen and delivered as separate independent pieces of work, and that objectives are not clearly aligned.	Existing governance - HWBB and EHWG.	4	4	16	The LLLB programme is being developed within the overall GM integrated care programme. The strategic aims and strategies for the three pieces of work are being aligned in Manchester through the agreed priorities of Manchester's Health and Wellbeing Board. The city wide leadership team for LLLB is particularly focussed on ensuring primary care is part of, and not separate to, the new community based care models. As we develop and deliver our communication and engagement plans for both our workforce and externally to our patients and customers, we will look to deliver a coherent and consistent message about what the changes mean for them, rather than the artificial boundaries of three interconnected programmes of work.
The structure of the health and care economy in Manchester is complex with three Clinical Commissioning Groups, four hospital trusts, the mental health and social care trust and Manchester City Council. There is a risk with this complexity that the LLLB strategy will be implemented and deployed differently through the three	Existing governance - HWBB and EHWG.	5	4	20	As we move from strategy to implementation in the LLLB programme it is essential that the overall strategic accountability for delivery of outcomes for Manchester people remains a priority for the Health and Wellbeing Board and its executive groups. The evaluation framework that we put in place for the programme must be developed to ensure that we can measure and evaluate progress across the whole system to

locality systems resulting in different service offers across the city.					ensure improved outcomes are delivered consistently across the city.
The financial picture for public services in Manchester over the next few years is extremely challenging with budget reductions for all statutory organisations in health and care services. There are clearly individual financial risks for each LLLB partner organisation which could result in service changes and instability for the medium and long term strategic aims of the programme.	Existing governance - HWBB and EHWG. Finance Steering Group.	3	4	12	It is clear that the increasingly difficult funding picture for public services mean that potential financial uncertainties for all LLLB partner organisations will need to be managed. The cost benefit analysis and ongoing management must continue to be co-owned by providers and commissioners. Funding and contracting arrangements put in place must be sustainable for all institutions and partners involved.
The strategic development of Living Longer Living Better in Manchester has been contingent on the relationships between commissioning and provider organisations in the City. The whole scale change of how health and care will be delivered in the future needs collaborative leadership from all sectors of the system. As Programme implementation activities get underway, there is a risk that these collaborative relationships will be strained or even break down as a result of strategic, legal and financial pressures, which could critically damage realisation of LLLB.	HWBB and EHWG. Links at CWLG level.	4	5	20	Over the next 6 months the governance structures that have been put in place to support delivery of the LLLB programme must be looked at and considered in terms of supporting the next five to ten years of sustainable change in our health and care economy. It must be ensured that we have appropriate forums and groups in place to tackle issues that arise and ensure implementation of our objectives is achieved over the medium and long term.

There is a risk that the financial planning being done by partners continues to be carried out in isolation, thereby resulting in contradictory expected financial outcomes across the system.	The Finance Steering Group chaired by Carol Culley (MCC) and Joanne Newton (CCGs)	3	5	15	Continued efforts by the Finance Steering Group to engender a sense of shared purpose and responsibility regarding financial planning, which needs to manifest itself in the Section 75/Pooled Fund agreement due in April 2015.
Given the complexity of the programme, there is a risk that the leaders on the CWLG fail to articulate both the progress and the ambitions of LLLB effectively to their own organisations and LLLB related governance bodies, thereby putting the credibility of the programme at risk.	Each partner organisation has LLLB related governance forums at which messages are disseminated.	3	5	15	The LLLB Strategic Plan to be delivered to the HWBB in September 2014 will be preceded by a period of consultation with organisational leaders, and will, as one of its objectives, look to improve the way objectives and progress are communicated.
The stability of the organisations partnering together to deliver LLLB, and the continuity of leaders involved in the Programme, is key to maintaining focus and successful delivery. Given the recent history of wholesale structural change in the Health & Social Care sector, there is a risk that this stability and continuity will not continue through the lifetime of the programme.	The CWLG provides the focus for organisational leadership.	3	5	15	Leaders on the CWLG will raise concerns and issues as soon as is practical to allow mitigation and contingency plans to be drawn up.
The capacity of the partner organisations to contribute to the delivery of LLLB is variable, given financial pressures and competing intra-organisations objectives. This puts the ability to deliver at scale and	A variety of resourcing arrangements across the partners.	4	5	20	CWLG leaders will continue to emphasise the importance of LLLB in their own organisations, and keep LLLB firmly 'on the agenda'.

pace at risk.					
Each partner organisation has inherent difficulties in managing the flow of patients across organisational and geographical boundaries that stretch beyond the Manchester city boundary. The programme itself is set up to deliver a new community based care system for Manchester only. There is a risk that competing boundary issues may adversely affect the focus given to Manchester services.	TBC	4	3	12	The CWLG will establish a working group over 2014/15 to address boundary issues in relation to LLLB
Clinical leadership is crucial to making LLLB work, particularly in terms of shifting resources safely and effectively from in-hospital to community settings, and ensuring the patient risk management culture shifts as a result. There is a risk that competing pressures on clinical leaders time - some are getting more heavily involved in GPPOs for example - may mean they deprioritise LLLB.	Clinical Boards and/or Integrated Care Boards exist in each locality. The LLLB Reference Group also draws part of its membership from clinicians.	4	4	16	CWLG leaders will continue to work with clinical leaders to engage them in the Programme and later in managing the external communications.

To a large extent the success of a new community based care system depends upon the engagement with and involvement of GPs. Given competing pressures on GPs time - formation of new GP Provider Organisations (GPPOs), links into geographical clusters of other provider groups (Provider Partnerships) and the Primary Care Programme, there is a risk that the delivery of LLLB is put at risk if engagement with GPs doesn't improve.	The LLLB Reference Group draws part of its membership from the Primary Care sector.	4	5	20	1) Refresh of the membership of the LLLB Reference Group to engage better with GPs, 2) Stronger links forged between CWLG and the Primary Care Programme, 3) Continued engagement and involvement of GPs through the locality MDTs.
The locality system support structures and governance structures are still evolving, as are the relationships between commissioners and providers. There is a risk that these structures and relationships diverge significantly from locality to locality, thereby making the task of striking common ground to deliver LLLB that much more difficult.	TBC evidence of existing city wide forums to mitigate this.	3	3	9	CWLG leaders working together to identify best practice and align ways of working where applicable.
Demand for services is still rising across the system. There is a risk that continued increases in demand will outweigh the gains made from more efficient and cost effective services.	Each organisation pursues interrelated demand management strategies.	4	5	20	Closer links will be forged with Public Health Manchester and MCC universal services to broaden the prevention offer to residents.

The viability of the continued investment in new, innovative community based services is put at risk by an inability to recycle funds back into the shared investment fund. This inability could stem from new services inducing demand and/or tapping into previously unknown quantities of latent demand, thereby making it difficult to judge whether a) the new service is successful, and b) stop the new service and recycle funds.	The local and citywide governance structures set up around the BCF/LDF.	3	5	15	An evaluation framework at tool is currently being developed which will, as part of the wider framework, seek to identify where this is occurring. Similarly, evaluation mechanisms built into BCF business cases will also address this.
The viability of the continued investment in new, innovative community based services is put at risk by an inability to recycle funds back into the shared investment fund. This inability could stem from a lack of understanding and/or agreement on the way the funding should flow across the system in terms of spend and benefits accrued.	The local and citywide governance structures set up around the BCF/LDF. The Finance Steering Group chaired by Carol Culley (MCC) and Joanne Newton (CCGs)	4	5	20	The Finance Steering Group will look to map the way money flows across the system in 2014/15 as part of the development of the Section 75/Pooled Fund agreement..
The way patient safety risk is managed at present can often result in resident admission to hospital/residential care settings . The ability of the programme to shift activity from hospitals into the community requires a review of safety risk management.	TBC	3	4	12	This risk will be analysed further as more new delivery models are up and running in 2014/15, keeping in mind the need for strong support from clinical leaders.

The infrastructure workstreams the Programme has identified - IM&T, Estates and Workforce in particular - may well need a multi-agency approach that stretches beyond the scope of LLLB. There is a risk that the wider the delivery agenda for these workstreams, the less likely they are to deliver for the Programme in the timescales required.	Domain' working groups.	3	4	12	All workstreams will be refreshed on the Strategic Plan is signed off by HWBB in September 2014. This refresh will take account of this risk.
There is a risk that demands on workforce supply are not modelled effectively over the lifecycle of the programme, and therefore not addressed effectively, given the range of variables acting on workforce supply. These include: organisational transformational programmes resulting in workforce reductions; national workforce strategies led, for example, by Health Education England (HEE); and natural fluctuations in workforce supply, amongst others.	Workforce Domain	3	4	12	To be built into the work programme for the workforce domain.

Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS (V0.8)

a) Summary of Plan

Local Authority	**Manchester City Council**
Clinical Commissioning Groups	**North Manchester CCG**
	Central Manchester CCG
	South Manchester CCG
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£42,090,000**
Total agreed value of pooled budget: 2014/15	**£32,671,000**
2015/16	**£42,890,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	North Manchester CCG
By	Martin Whiting
Position	Chief Clinical Officer
Date	
Signed on behalf of the Clinical Commissioning Group	Central Manchester CCG
By	Ian Williamson
Position	Chief Officer
Date	
Signed on behalf of the Clinical Commissioning Group	South Manchester CCG
By	Bill Tamkin and Caroline Kurzeja
Position	Chair and Chief Officer
Date	

Signed on behalf of the Council	Manchester City Council
By	Sir Howard Bernstein
Position	Chief Executive
Date	

Signed on behalf of the Health and Wellbeing Board	Manchester Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Sir Richard Leese
Date	

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

Document or information title	**Synopsis and links**
Integrated Care Blueprint (March 2013)	http://www.manchester.gov.uk/meetings/meeting/1886/health_and_wellbeing_board A document developed by the eight partners confirming the rationale and ambition behind the Living Longer, Living Better (LLLB)

	Programme for integrated health and social care services in Manchester.
LLLB Strategic Outline Care (July 2013)	http://www.manchester.gov.uk/meetings/meeting/2052/health_and_wellbeing_board The strategic outline case details significant progress in areas which are critical to the future development of integrated care, namely the target population, the care models, and the contracting and funding arrangements. It also summarises further work undertaken, and planned, in a range of other important workstreams of the integrated care programme.
LLLB Strategic Business Case (November 2013)	http://www.manchester.gov.uk/meetings/meeting/2058/health_and_wellbeing_board This strategic business case builds on the LLLB Blueprint submitted in March 2013 and the Strategic Outline Case submitted in June 2013. In particular, it: Re-affirms the case for change and the rationale for the LLLB programme. • Describes for the first time a much deeper understanding of the different population groups in Manchester, highlighting how different population groups access and use different health and social care services across different commissioners and providers in the city. • Details the care models that are in development for the priority population groups in the city, articulating the macro changes required in how and where we deliver health and social care services, including the practical 'big ticket' items that we will focus on in the short term to make out of hospital care a reality on the ground. Provides the high level financial case for change and the forecast impact of the priority care models within the Living Longer Living Better programme, across commissioners, providers, population groups and settings of care.
LLLB Strategic Plan for 2020	**http://www.manchester.gov.uk/meetings/meeting/2259/health_and_wellbeing_board** The purpose of this document is to refresh the strategic vision and objectives of the LLLB Programme in light of progress made over 2013/14, and to present a delivery plan for 2014-2015, along with an indicative plan for 2016-2020. This Plan builds on previous strategic documentation produced by the Programme, including the Integrated Care Blueprint (March 2013), the Strategic Outline Case (July 2013) and the Strategic Business Case (November 2013) and supersedes them in that it should be regarded as the main reference point for the Programme from now onwards.
Mancheste	http://www.manchester.gov.uk/meetings/meeting/1886/health_and_we

r Joint Health & Wellbeing Strategy	llbeing_board Sets out the vision for health and wellbeing in Manchester, and sits alongside Manchester's JSNA and Community Strategy.
Mancheste r Joint Strategic Needs Assessme nt	http://www.manchester.gov.uk/info/500230/joint_strategic_needs_asse ssment Manchester's Joint Strategic Needs Assessment (JSNA) draws together the best available evidence on the current and future health needs of residents across the city and seeks to drive the strategic commissioning of a wide range of partners within Manchester City Council, the NHS, clinical commissioning groups, voluntary and community sector and other partners.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Context

Manchester's Integrated Care Programme is called 'Living Longer, Living Better' (LLLB), a title that represents the Manchester Health & Wellbeing Board's (HWB) aspirations for residents of the city.

The LLLB Programme has eight core delivery partners, that represent the main providers and commissioners of health and social care services in the city:

- Manchester City Council (MCC),
- Manchester Mental Health and Social Care Trust (MMHSCT),
- North Manchester Clinical Commissioning Group (NMCCG),
- Central Manchester CCG (CMCCG),
- South Manchester CCG (SMCCG),
- Pennine Acute Hospital Trust (PAHT),
- Central Manchester Foundation Trust (CMFT),
- University Hospital South Manchester (UHSM).

These core delivery partners each have a nominated senior leader responsible for the delivery of LLLB; these senior leaders all sit on a weekly Citywide Leadership Group (CWLG) that drives the delivery of the Programme. There are a number of related forums and working groups that draw on clinical and specialist expertise, and ensure the voices of the voluntary sector and residents are heard and help shape the programme. See section 4b for more on governance.

Vision for 2020

LLLB has produced a number of strategic documents over the last 18 months, including an Integrated Care Blueprint (March 2013), a Strategic Outline Case (July 2013), a Strategic Business Case (November 2013), and a Strategic Plan for 2020 (September 2014). All these documents are underpinned by strategic principles agreed by partners in the Integrated Care Blueprint. The Strategic Plan for 2020 supersedes previous documentation and defines clearly a vision and strategic objectives and sets out a plan to get there. The intention is for this plan to be updated yearly, allowing Manchester's HWB to agree yearly work programmes.

The vision statement below, presented in the Strategic Plan for 2020, is indented to be unambiguous, and encapsulates the scale of the challenge ahead, whilst acting as a focus for the enthusiasm and activity of all partners involved in LLLB.

"By 2020, the LLLB Programme will have radically transformed Manchester's community based care system. This transformation will support people to live longer, healthier lives by ensuring a wide range of high quality health and social care services are easily accessible within communities, and are centred on the individual and their specific health needs."

The contrast between the current health and social care system and the vision outline above is stark, in that Manchester's ambition is to create a community based care system that can accommodate a 20% shift of activity from in-hospital services. Work is ongoing to map and evaluate existing community based care services across the city, and to develop a high level design for 2020. This high level design will be built upon up to 2019/2020, informed by the evaluation of investment plans that draw upon BCF funding.

Strategic Objectives

Four strategic objectives underpin the vision:

IMPROVING HEALTH OUTCOMES - Contribute to an improvement in key quality of life and life expectancy outcomes in Manchester by driving improvements in the community based care system, ensuring a range of new, innovative place-based services are centred on the individual.

IMPROVING SERVICE STANDARDS - Ensure that the new community based care system delivers high quality, easily accessible services regardless of where in Manchester an individual lives.

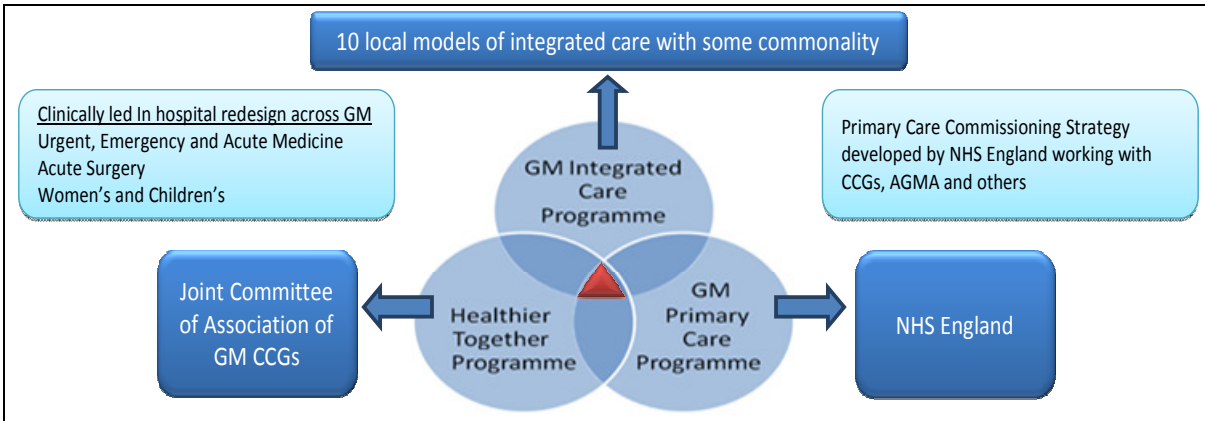
FINANCIAL SUSTAINABILITY - Deliver a financially sustainable community based care system for Manchester that enables a safe reduction in the overall spend on health and social care services and a rebalancing of resources from in-hospital to community based care.

SUPPORTING SELF RELIANCE - Increase the volume, range and effectiveness of prevention and early intervention services available, including a wider choice of resident self-care options, to enable people to maintain their independence within a strong community support network.

Strategic Thread

The strategic environment of which LLLB is a part is complex. It will constantly shift and change as decisions on organisational priorities and funding are periodically reviewed, and as feedback from staff and citizens on the new services being delivered is incorporated into future programme planning and design. The current strategic environment is presented in outline in this section.

At a **Greater Manchester** level, the overarching strategic lead stems from the Public Sector Reform Programme, which encompasses Complex Dependency and Health and Social Care Integration. Health and Social Care Integration is split into three interrelated programmes, set out below:



Both the Integrated Care Programme and the Primary Care Programme are seeking to transform out-of-hospital health and social care services, and although they operate across Greater Manchester, delivery will take place in each Local Authority and CCG area. The Healthier Together Programme is a Greater Manchester programme which will transform in-hospital services.

At a **Manchester** level, LLLB is the city's integrated care programme. Strategically, it takes its lead from the Greater Manchester context, above, and Manchester's Joint Health & Wellbeing Strategy (JHWS), as determined by the Manchester's HWB. In particularly, LLLB delivers against five specific priorities of the JHWS:

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

The JHWS is informed by Manchester's Joint Strategic Needs Assessment (JSNA) which ensures that the JHWS draws on sound evidence and information on health needs, contributory factors and priority areas. The JSNA draws together the best available evidence on the current and future health needs of residents across the city and seeks to drive the strategic commissioning of a wide range of partners within Manchester City Council, the NHS, clinical commissioning groups, voluntary and community sector and other partners. The five priorities outlined above are part of a suite of eight priority areas identified through the JSNA that form the basis of the JHWS.

b) What difference will this make to patient and service user outcomes?

The Strategic Priorities for LLLB listed in the previous section set out the broad areas in which the Programme expects to make a difference to the lives of Manchester citizens.

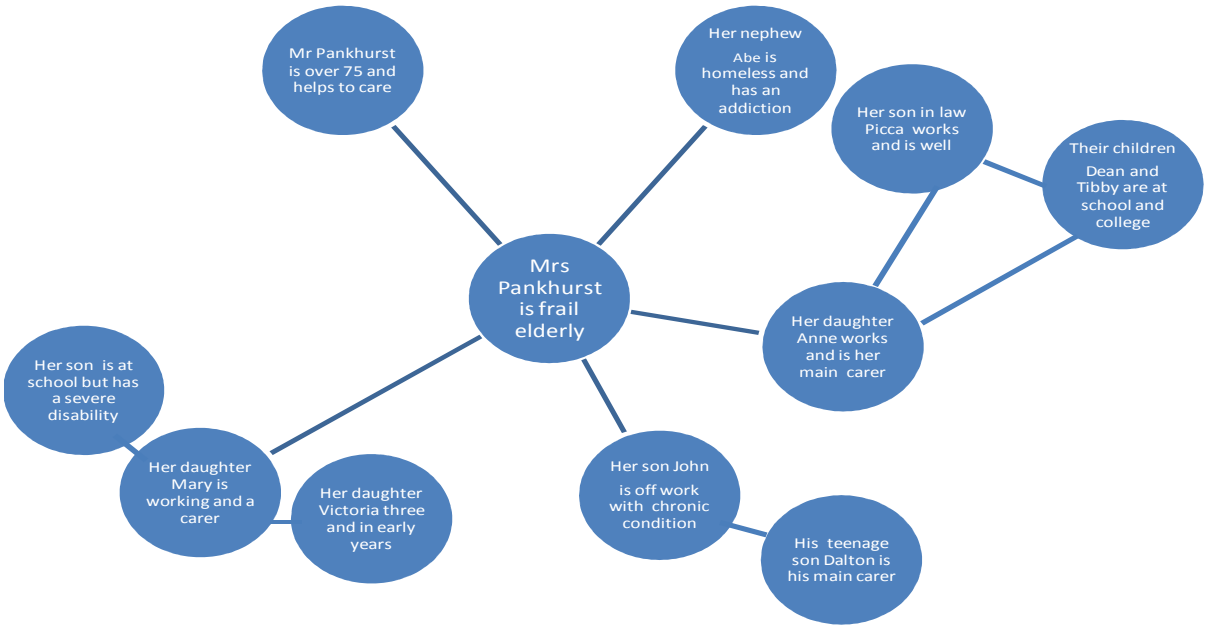
The Programme is underpinned by a three tier evaluation system which will measure patient and service user outcomes:

- Locality economy/system level, evaluating the outcome of BCF investments in new service delivery models, as defined in specific business cases,
- A performance management framework which includes the key indicators being

monitored and measured across the health and social care system,
- An evaluation plan, drawing on best practice research and evaluation methodologies recently developed in Manchester to support wider Public Sector Reform activity.

The Programme governance structures have been developed to ensure patients and service users have a stake in the Programme, and that their feedback on developments in the community based care system is regularly canvassed and built into programme planning. See section 4 for details of governance arrangements, and section 8 for more detail on engagement.

More specifically, the LLLB Programme introduced "Mrs Pankhurst" and her family at an early stage, building on feedback from residents and service users, in order to help articulate the vision for services on the ground:



The future: 2020

- Mrs Pankhurst has 24/7 co-ordinated care, with a named worker who can wrap services around her as an individual. She has one urgent care number to ring at any time of the day knowing that she will be known through her care plan, listened to, triaged and given appropriate care in a 4-hour period 24/7 in her home, community facility or if needed hospital. Mrs Pankhurst uses equipment to support her daily living (the environment design enables her and reduces the need for physical support) and is able to speak to the team via Skype or video calls.
- Mrs Pankhurst feels cared for; she is treated with dignity and given information and care to meet her personal concerns and goals which will include decreasing her pain, increasing her comfort and environment at home and giving her support and choice about how to live the remainder of her life with dignity.
- Mrs Pankhurst's daughter Anne will be offered co-ordinated support and information to enable her not only to care for her mother appropriately but to carry on working and caring for the rest of her family including her school aged children.

Anne feels well and able to cope.

- Anne's children are knowledgeable about their life styles and their life choices and inspired to live healthy and productive lives. They use technology and services in the community appropriately to self-manage any short-term illness and are aware of risks of accidents and illness through addiction. They have first aid skills to manage most minor injuries.
- Picca is working within one of the new delivery models in the city and is an advocate for caring differently and being able to inspire people to live more healthily, he is volunteering at a local sports centre to coach a youth team.
- Mr Pankhurst has regular screening and health checks. He is supported to enable him to remain well and living independently in the community. He is sharing "Mrs Pankhurst's" care with Anne and is involved in her future care planning.
- John is at work and self-managing his long-term conditions of Chronic Obstructive Pulmonary Disease and diabetes. He has a clear and owned care plan and has learnt how to use technology to enable him to manage his condition with knowledge. He has information about the new delivery model, and feels that, when he needs it, it is responsive to his needs with regular checks and care planning.
- Dalton, his son, is no longer losing days at school in order to care for John and is able to have time to do his homework and socialise with friends. He is now projected to achieve good grades in his GCSEs.
- Mary is able to work and care for both her children, Victoria has had a coordinated programme of screening, immunisation and care in her early years and is now ready for school with the potential to do well. Her son has a shared care plan that Mary understands and a coordinated package which enables him to attend school and be cared for at home when he needs extra support.
- Abe is now in accommodation and has been supported to get a part time job; his health has improved through a coordinated package of care. He is knowledgeable about where to go and how to manage his addiction and illnesses when necessary.

Early indications

The communications professionals from partner organisations supporting the LLLB Programme regularly seek out feedback from service users who have experienced the new delivery models already being implemented in Manchester. Several case studies and news features have been produced (available on request) which demonstrate that the changes Manchester is making to its community based care system is having a positive impact upon the lives of Manchester citizens, turning the Pankhurst Family vision above into reality.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Changes to the pattern and configuration of services.

As noted in section 2a above, Manchester's ambition is to create a community based care system that can accommodate a 20% shift of activity from in-hospital services. Section 3, below, outlines the key changes that need to take place to make this work, namely: co-ordinating care around the individual; removing the barriers that users face when accessing health and social care; providing care (including earlier intervention) at the most appropriate location; and supporting independence.

Broadly, this will require:

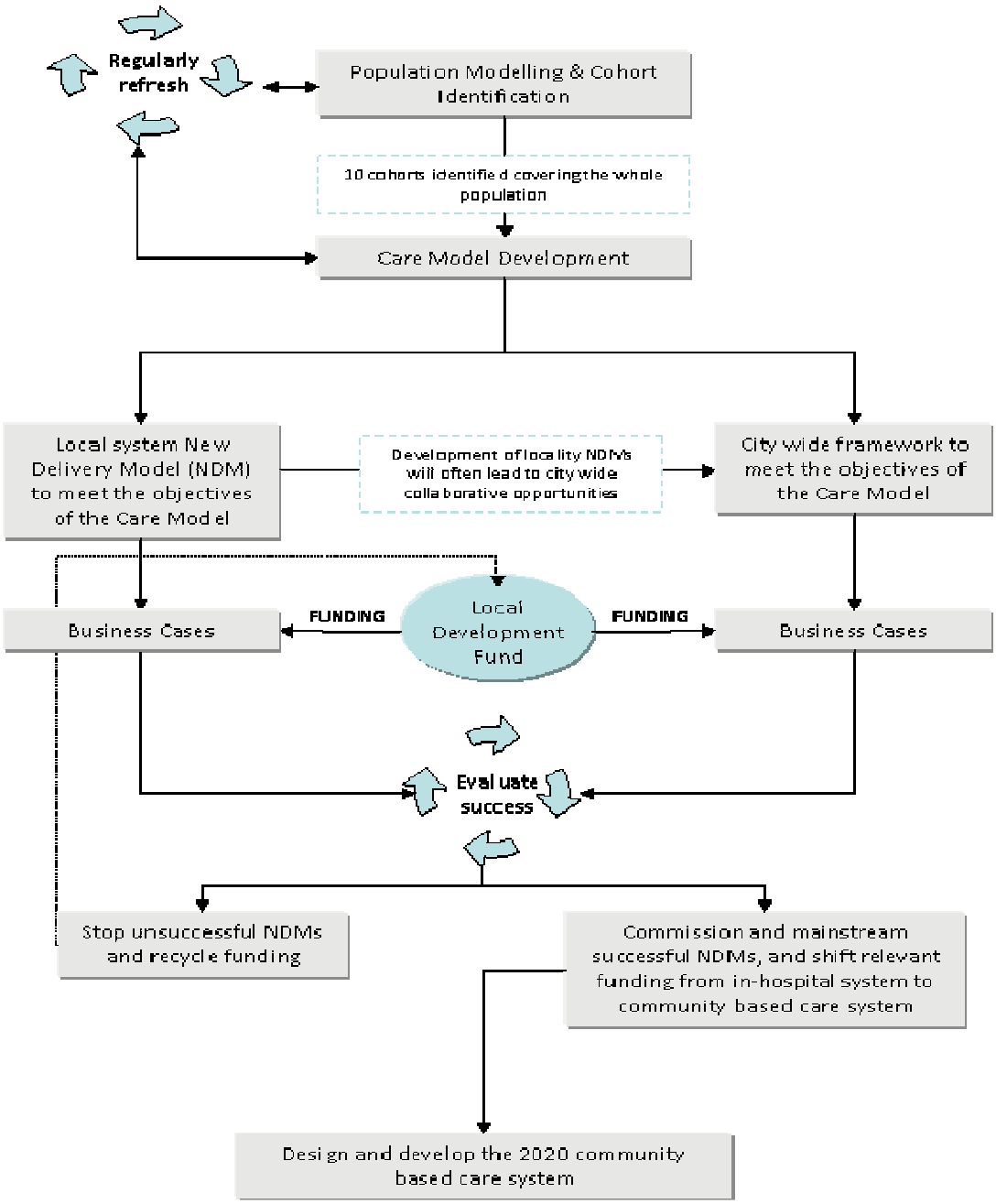
- Joined up delivery. Not just inter-organisational in terms of the eight partners but linked more effectively with private and voluntary sector providers.
- Joined up budgets, with the planned Section 75 agreement paving the way.
- Joined up infrastructure. This includes access points, information management and technology, estates, workforce development amongst others. Section 4b lists the Programme workstreams that have been established to deliver this work.
- Expansion in preventative and early intervention services. Better use will be made of 'universal services' (leisure centres, libraries etc.) to support public health initiatives, and self care and self reliance amongst Manchester citizens will be supported and encouraged.
- Culture change, amongst our health and social care staff to deliver the prevention and intervention outcomes, and amongst citizens in terms of how they interact with health and social care services.
- Right care, right time, right place. Care will be person centred, delivered in the location of their choice at the time of their choice wherever possible.

In effect, each stage of the service user's journey will need to be remodelled to enable the Vision for 2020. Underpinning all of the above will be a better understanding of how to manage demand more effectively. Manchester realises that there is a risk of tapping into latent demand and inducing more demand by not accurately estimating and evaluating the impact of new or extended services. The evaluation plan mentioned in 2b, above, will drive this work.

In addition to the above, Manchester's community health providers are currently working collaboratively with Manchester City Council to define the efficiencies and benefits of joining services more closely together. It is envisaged that this work will be progressed at pace over the next months. It is anticipated that if services are joined up, this will effectively support the delivery of BCF funded work, particularly in terms of scale and pace.

BCF funded contribution

Manchester is using £20m of the BCF as an innovation fund to develop new, or sustain successful exiting pilots and initiatives to deliver the changes identified above. The Manchester Care Models (see section 3 below for more) define clearly the commissioning outcomes and standards for each specific patient/service user cohort agreed collectively by the three Manchester Clinical Commissioning Groups (North, Central and South) and Manchester City Council. They identify what 'success' look like for the cohort, and define the outcomes commissioners expect. The BCF funds the new delivery models developed by providers to deliver against the care models. The model below sets this out diagrammatically, where 'Local Development Fund' represents the innovation funding pot:



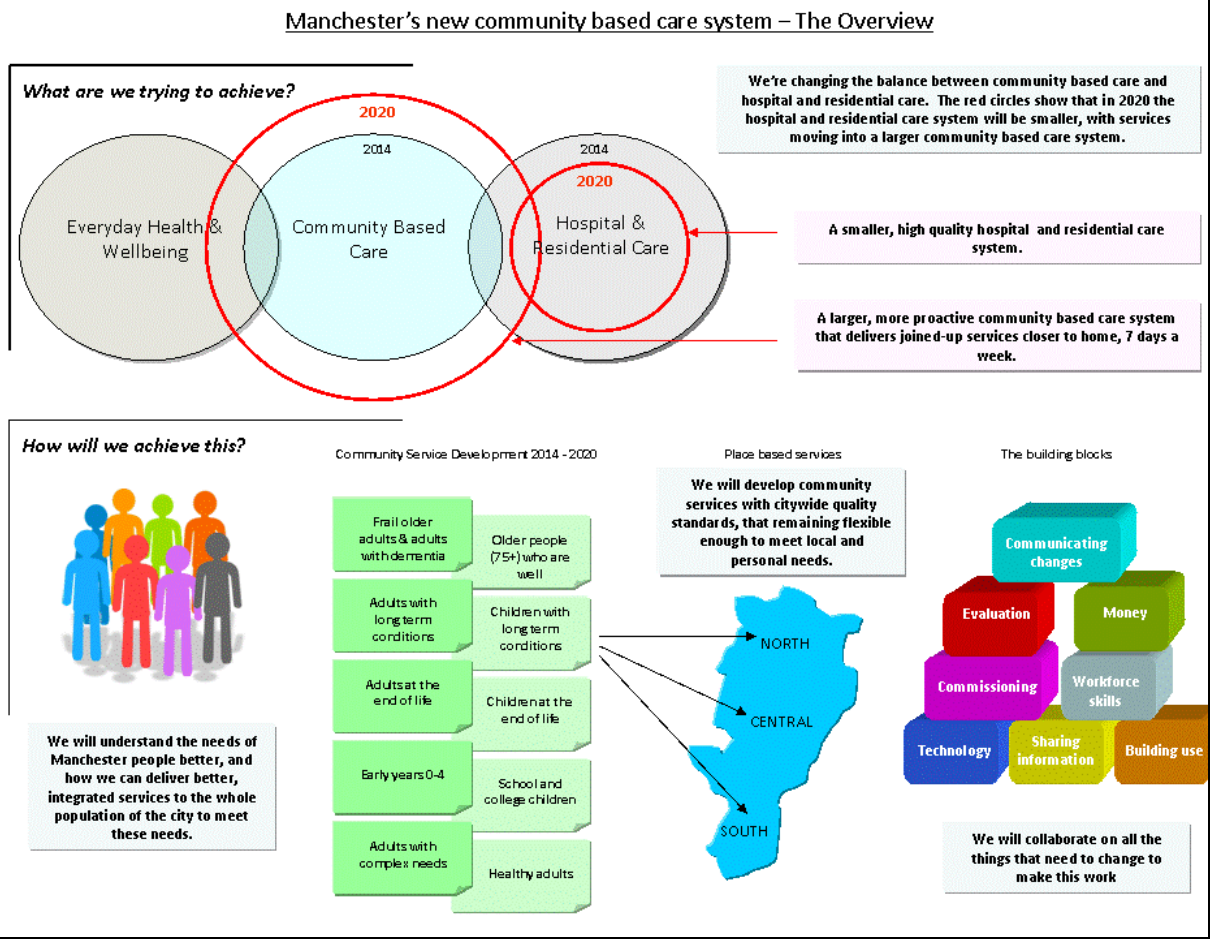
Each new delivery model has a number of common features, including:

- *Co-production with patients, carers and the community*. A model designed with and co-delivered by the people and communities that will use it. The mechanisms for engaging with service users and representative organisations are outlined in sections 4b and 8a below.
- *Coordinated services* creating choice, independence and enabling care to be provided in the community,
- *Generic multi disciplinary teams* in each locality that can care for a person throughout their illness,
- *New diagnostic / assessment tools* used by patients/residents and providers across the system to more consistently identify needs earlier,
- *Specialist team(s)* that will be able to give coordinate care to a patient and their

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

The BCF, therefore, is directly supporting three key development areas in Manchester:
- **Investment in new, innovative ways of working** as outlined above,
- **Development and strengthening of the strategic coalition of partners** – the processes partners have agreed to follow to draw down BCF funding (Care Model development, new delivery models development, business case development, governance) all strengthen collaboration and trust between commissioners and providers.
- **Development of a Section 75 agreement** – whereby the agreements in place around BCF funding lay the groundwork for section 75 agreements.

The infographic below outlines Manchester's approach, leading into the rationale in section 3 below.



3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Manchester Context

Much of the statistical information related to the health of Manchester population can be found in Manchester's Joint Strategic Needs Assessment (JSNA) which can be accessed through the council's website here - http://www.manchester.gov.uk/info/500230/joint_strategic_needs_assessment

The JSNA feeds the Joint Manchester Health & Wellbeing Strategy (JHWS) which can be found here: http://www.manchester.gov.uk/meetings/meeting/1886/health_and_wellbeing_board

LLLB in turn takes its lead from the JHWS. The health and social care data and analysis contained in these two documents will not be repeated here, given space constraints. However, to give some further context for this Plan, the paragraphs below give an overview of the key issues.

Key issues

Manchester is a dynamic city with a growing population, with the highest levels of growth coming from an increase in young adults living in the city. However, there are high levels of deprivation in the city; Manchester was ranked the 4th most deprived local authority in England in the 2010 Index of Multiple Deprivation. Manchester has amongst the highest non elective bed days for over 65s in the country and is in the upper quartile for emergency admissions and A&E attendances.

Health outcomes are poor and lag behind other parts of the country. In common with other areas, Manchester has an increase in the number of older people living in the city but high prevalence of long term conditions such as cardiovascular and respiratory disease mean that Manchester residents not only have a shorter life expectancy but can expect to experience poor health at a younger age than in other parts of the country.

Manchester women have the worst life expectancy in England and men the second worst. The latest figures for 2010-12 show that Manchester has 4th lowest healthy life expectancy (HLE) for men and the lowest HLE for females. Specifically, a boy born in Manchester can only expect to live 75% of his remaining years of life in good health compared with 86% of remaining years of life for a boy born in Richmond. A girl born in Manchester can only expect to live 70% of her remaining years of life in good health compared with 84% of remaining years of life for a girl born in Wokingham. Both men and women have significantly lower levels of HLE at birth than the England average.

A study into health and social care commissioned by the partners in Manchester's health and social care system carried out in 2012 found that the system required considerable change. The quality of, and access to, services are variable with care provision often fragmented and uncoordinated across the city and the use of the acute sector for the delivery of services is high relative to the national average with people using hospitals because of a lack of alternative provision in the community. Too often, this results in patients receiving reactive care to urgent needs instead of

earlier, planned and more cost effective intervention.

More specifically, the Health Intelligence function of Manchester's Public Health Team actively supports the LLLB Programme, identifying and reporting areas of unmet need and ensuring this information is fed into the development of Care Models and new delivery models. For example, the prevalence of diagnosed conditions amongst GP practices in Manchester is observed and modelled, with the difference between the two indicating unmet need. Similarly, the six BCF metrics are being tracked, and Manchester has chosen the dementia metric as its local metric. In 2014, Manchester aimed to see a dementia diagnosis rate of 64% (i.e. 64% of the estimated number of patients with dementia were known to GP practices and recorded on their dementia registers). The actual figure is 65.7%, exceeded the target and providing an example of where need is being met.

Drivers for Change

The two main drivers for change raised in the study can therefore be summarised as: a complex fragmented system; and a system which is rapidly becoming financially unsustainable.

A complex, fragmented system

Manchester's citizens live in a city with a vast range of health and social care access points. Manchester has four hospital trusts with a range of buildings, 98 GP Practices on numerous sites, a city council contact centre, 50 community centres, and six social care district offices. Historically most of the sites tend to be organised around the service that runs from them rather than the person who needs the care. For patients who may have a number of long term conditions this may mean visiting numerous sites on different days for their care, rather than one where it is co-ordinated around them.

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

Manchester is also geographically small, with patient flows - particularly to the acute trusts - not matching locality boundaries within the city and an inflow of patients into the city's hospitals from outside the city. There are a significant number of patients registered with Manchester GPs who live outside the city (15% in North Manchester CCG); are eligible to receive health services in the city but are not eligible to receive social care services which are provided by their resident local authorities. Under the Transforming Community Services programme in 2011, adult community services were vertically integrated on a locality basis with the locality's acute trust. This has

helped improve coordination between acute and community services, however a legacy of different levels of community services and the flow of patients between localities means there is a need for much better levels of integration and consistency across the city.

A financially unsustainable future

The current health and social care system is unaffordable in the future. A combined financial pressure of circa £250m has been identified across the three main acute providers, the three CCGs, and MCC. Manchester needs a system that shifts demand and resource away from hospitals and promotes independence and self-care. This will need to involve a change in contracting and resourcing arrangements. Current arrangements are different across sectors of care. Some are designed locally and some are within nationally determined frameworks which have varying degrees of flexibility. It is not a coherent system reflecting how services should operate individually or collectively.

New contracting arrangements are in development in each of the three localities aimed at facilitating the integration of care. These will bring closer contractual alignment enabling health and social care partners to work towards and get rewarded for achieving common goals. Central Manchester, for example, has implemented a 'pre-alliance contract' for urgent care services, agreed by commissioners and providers, that includes financial incentives in addition to a shared performance framework. Under this arrangement, each provider organisation retains its existing bilateral contract with its commissioner for a significant proportion of the contract value and the remainder is part of an alliance contract between the commissioner and the partnership of providers. The intention is to implement a full alliance contract from April 2015.

In order to overcome these two challenges, the LLLB Programme will develop a health and social care system which commissions and provides more co-ordinated care in the community to enable people to live longer and live better. This means; co-ordinating care around the individual; removing the barriers that users face when accessing health and social care; providing care (including earlier intervention) at the most appropriate location; and supporting independence.

The LLLB Programme is expected to make a contribution to alleviating financial pressures of circa £20m, net of reinvestment in alternative services. The remainder of the financial gap is expected to be closed by other programmes including Healthier Together, Primary Care programmes and efficiency and change programmes for individual partner organisations.

The theory of change and logic behind the LLLB Programme is covered in more detail in the LLLB Strategic Business Case, which can be found here: http://www.manchester.gov.uk/meetings/meeting/2058/health_and_wellbeing_board

Risk stratification

The LLLB Programme is an integrated care programme for the whole population. That population has been segmented into 10 priority population groups. Population

analysis began by stratifying the population using a risk stratification tool (Combined Predictive Model). Early work in the three localities focused on developing integrated care models to manage patients with multiple long term conditions in the high and moderate risk cohorts. In defining an approach for working with the whole population, risk stratification alone was felt to be too simplistic; for example the very high risk cohort includes children and those with complex needs relating to mental health, drugs and alcohol and there are large numbers of older people in the lowest risk cohorts. The city has therefore divided its population into 10 priority population groups as follows:

- Adults and children at the end of their lives*,
- Adults with long term conditions*,
- Frail older adults and adults with dementia*,
- Adults with complex lives*,
- Children with long term conditions*,
- Children in their early years,
- Adults who are well,
- Older people over 75 who are well,
- Children 5-18 who are well,
- Adults and children who are carers.

The top five groups (marked *) were identified as the first groups to have care models developed. Section 2c outlines how Care Models and New Delivery Models have been developed for these groups.

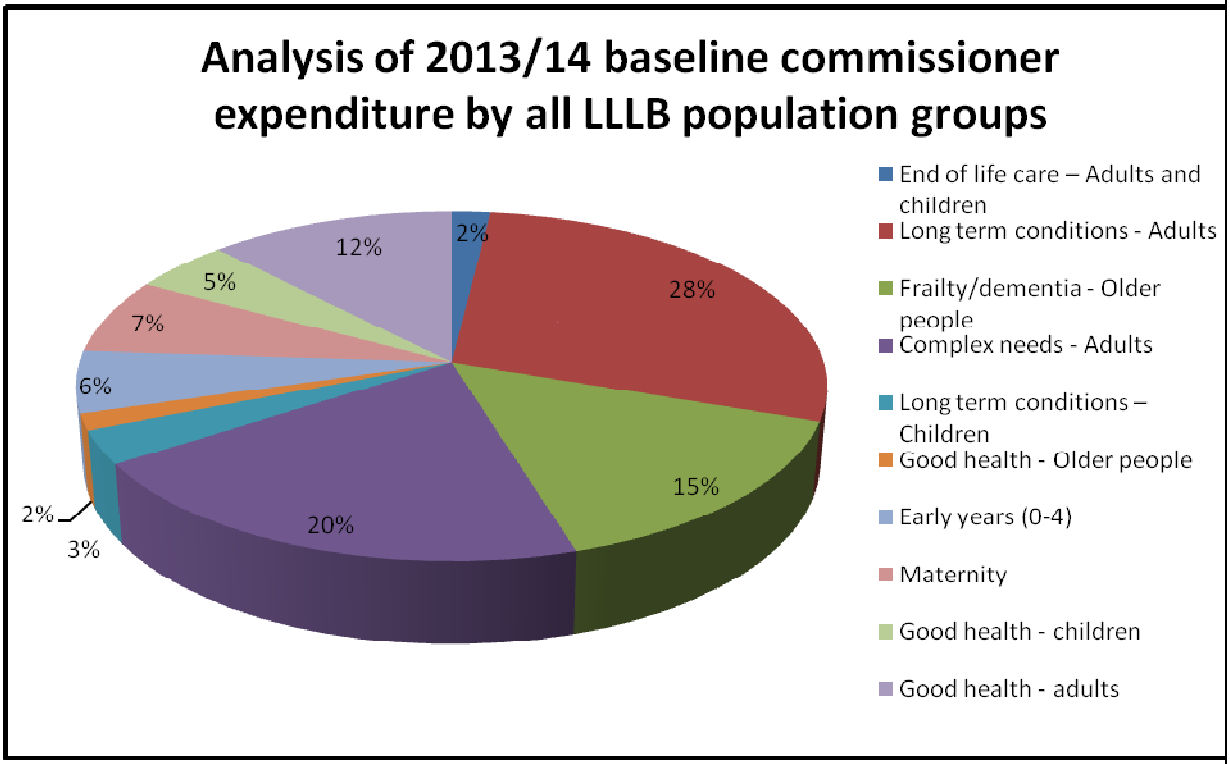
A financial model has been developed to capture current health and social care expenditure across the five priority target population groups. The LLLB financial model continues to be refined and will inform the basis of the formal Cost Benefit Analysis for the next wave of investment in the new delivery models during 2014/15. The aim is that the new delivery models should cost less than current services in absolute terms.

To date, the priority for costing the current health and care service provision has involved allocating and apportioning costs to the population groups to ascertain the current cost of health and social care across the LLLB programme areas. This will serve as a benchmark to test the cost base of the proposed new delivery models. The draft baselines for the **priority** population groups are included in the following table:

LLLB Population Group Analysis			
Priority Population Groups	**Full population 2012/13**	**% of total population**	**City Wide Health & Social Care Commissioning Costs**
End of life care – Adults and children	1,415	0.2%	£16,042,033
Long term conditions - Adults	116,597	20.4%	£242,153,631
Frailty/dementia - Older people	5,944	1.0%	£127,018,097
Complex needs - Adults	4,748	0.8%	£173,765,922
Long term conditions – Children	12,294	2.1%	£26,501,884

TOTAL	140,998	24.7%	£585,481,568

Mental Health commissioning costs sit mainly within the Complex Needs and Long Term Conditions population groups.



Please note – the 'Maternity' population group has since been included in the 'Adults who are well' care modeling work.

This chart shows the proportion of resources absorbed by each population group across the combined City wide health and social care commissioning budgets in 2013/14. This includes £167m of Manchester City Council's Adult Social Care funds and £684m of the three Manchester CCGs' total budgets.

The five priority population groups represent approximately 24.5% of the Manchester population but absorb circa 68% of overall resources. The values to date will provide a basis from which to monitor the changes in cost base for the proposed new models of care, as the LLLB Programme and supporting business cases develop.

The scale and complexity of the LLLB programme in terms of developing new models across the City involving a range of stakeholders across five priority population groups, means that the full cost of all future models continues to be established. This is on an incremental basis, taking into account the costs of all new business cases and their projected efficiencies.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Context

The LLLB Programme is run along best practice programme management principles, and is supported by a small programme office that is jointly funded by the eight partners. The programme office ensures that projects, workstreams and initiatives are planned and managed effectively. In terms of the delivery of the Vision for 2020 presented in section two, the delivery of the BCF Plan sits within the larger LLLB Programme Plan.

BCF Plan milestones (post submission of this plan)

The high level delivery milestones related to BCF are as follows (it may be useful to refer to the innovation model in section 2c when reviewing the milestones below):

- November 2014 - Update of existing Care Models.
- November 2014 - Development of next set of Care Models.
- October to December 2014 - Evaluation of current BCF investments to inform the next investment round.
- October to November 2014 - Refreshed business case process to draw down BCF funding, linked to 2014/15 priorities as set out in the Strategic Plan and the emerging Section 75 agreement.
- December 2014 to January 2015 - Development of New Delivery Models to meet the objectives of the new Care Models
- November 2014 to March 2015 – Rolling approval period for business case submissions to draw down BCF funding to support the implementation of New Delivery Models.
- April 2015 – Section 75 partnership agreement signed.
- April to June 2015 - Implementation of new delivery models following business case approval and release of BCF funds.
- June 2015 onwards – Evaluation of BCF investments to inform the next round of investment in 2015/2016.

Key interdependencies

The LLLB Programme does not sit in isolation, and the interdependencies are many and varied given the complexity of the operating environment in the city and at a GM level. The interdependencies identified below represent the major areas of focus:

- GM Public Sector Reform Programme, in particular the Complex Dependency Programme,
- GM Integrated Care Programme, including Healthier Together (programme to transform in hospital services),
- Primary Care Programme,
- Other city wide improvement programmes, including (but not limited to) the Mental Health Improvement Programme, Macmillan Cancer Improvement Partnership, and the Wellbeing and Lifestyle Services Redesign Programme,
- The transformation programmes currently underway in each of the eight core partner organisations,
- Environmental changes, particularly legislative, the Care Act for example.

The interdependencies vary in nature too, from impacts on the shape and direction of the programme itself (for example the collaborative direction set across GM by the GM Integrated Care Programme) to smaller impacts upon specific Care Models (for example Macmillan Cancer Improvement Partnership and the End of Life Care Model).

Interdependencies are managed by the LLLB CWLG, and the LLLB Programme Office. Each CWLG member has a 'portfolio' of stakeholders they are responsible for building operational relationships with, which represent the interdependencies above. The interdependencies themselves are managed through the LLLB CWLG, with collaborative opportunities arising through Programme workstreams, risks and issues captured on the Programme risk log and escalated through the HWB as necessary.

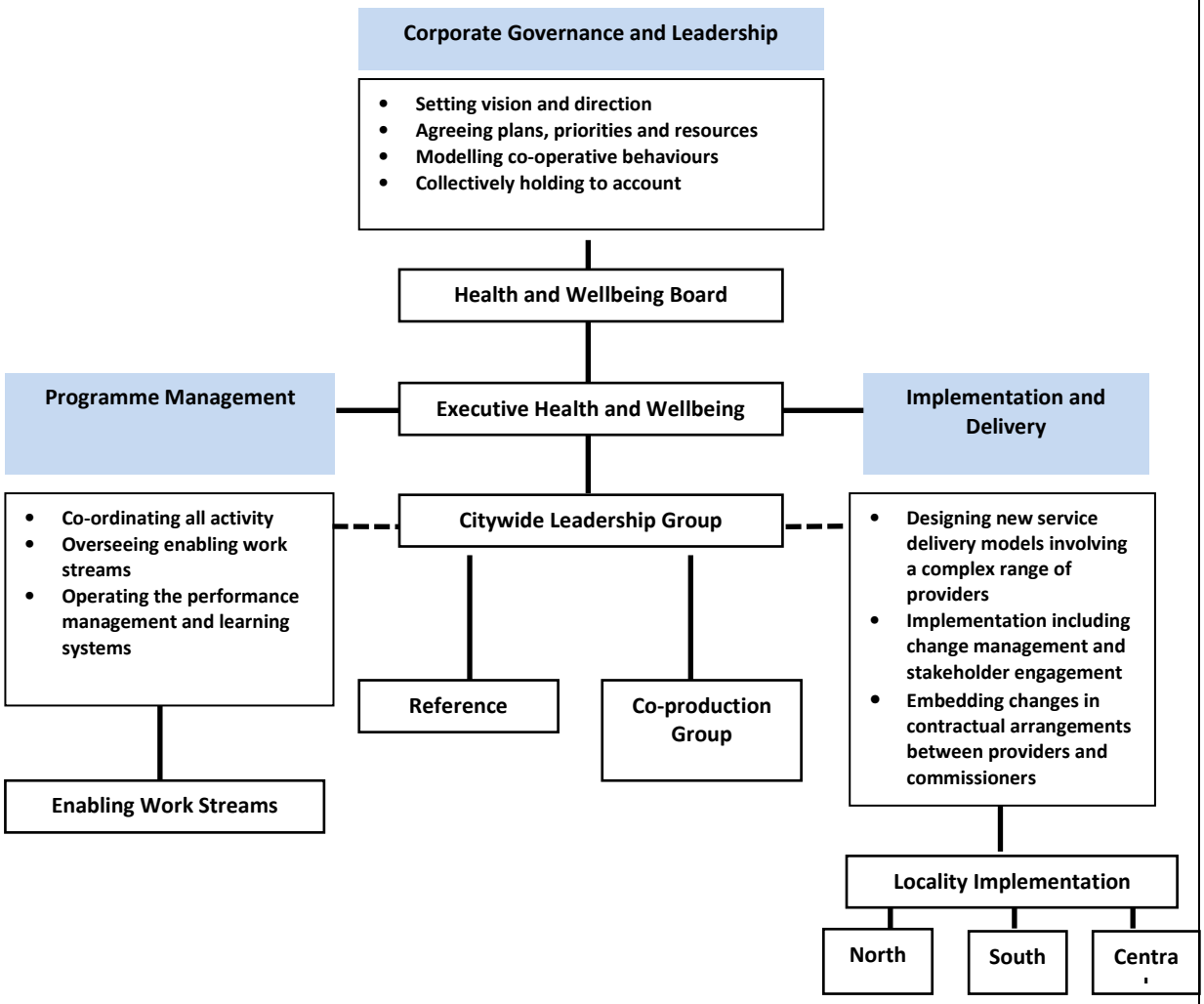
Further details on specific interdependent programmes and projects can be found in section 6a.

b) Please articulate the overarching governance arrangements for integrated care locally

Citywide Governance

One of the key leadership challenges in the Programme is to secure agreement amongst partners and stakeholders to make decisions about the future community based care system on a citywide basis, and to develop formal governance structures that facilitate this. One of Manchester's strengths is that it has both Providers and Commissioners involved throughout the governance structure, and has established forums and mechanisms for Providers and Commissioners to come together and actively collaborate on achieving the Vision for 2020; the CWLG is an example of this.

However, the related challenge is to continue to recognise the value and necessity of locality decision making structures. Commissioners still have to coordinate existing contacts and payment mechanisms alongside the development of new services, and continue to carry the risk related to these existing arrangements. All locality systems have different starting points related to the make up of hospital and community services, and all operate over different geographical boundaries. The CWLG will continue to work to ensure local governance works in harmony with citywide governance. The following governance diagram was presented to the HWB in early 2014, and still provides a good high level overview of Programme governance:



The **Reference Group** is a key aspect to the governance of the programme as a whole. The group acts in an advisory capacity to the CWLG to ensure that the programme planning, design and implementation is sound. The membership of the reference group incorporates key people from within the health and social care system (clinical specialists, voluntary sector and community representatives) who are able to provide the programme with their perspective and expertise.

The **Co-Production Group** has been established to make sure that people who use services, their families and carers have a chance to help design the changes. It will do this by making sure that all those who are responsible for different parts of the change involve people who can represent others like them (e.g. young people, older people, people with the same condition or disability, people from the same cultural group) in the design process.

Governance and collaboration

The LLLB CWLG has a number of workstreams that provide the mechanism for all eight core partners, and other relevant partners and programmes, to collaborate on

the joint design and delivery of solutions to support the vision for 2020. These workstreams include:

- **System Innovation**

Including the development of Care Models and new delivery models, the design of the community based care system, and continued research and intelligence work related to population modelling.

- **Infrastructure**

Including three workstreams: Information Management & Technology (IMT); Estates; and Workforce. These workstreams are grouped together because they are dependant on the evolving design of the new community based care system to determine the parameters in which they operate. Their scope will expand as necessary to take account of related programmes and strategies at both a city and regional level.

- **Performance Monitoring and Evaluation**

Including the development and operation of the performance and evaluation framework. This framework will link system wide indicators with the evaluation of BCF investments.

- **Commissioning Innovation**

Including the further development of innovative contracting arrangements and the commissioning decisions related to the evaluation of BCF investments.

- **Financial Innovation**

Including the development of a Section 75 agreement to pool funds into a Local Development Fund, the further refinement of financial targets for health and social care and the development of processes to support the flow of money, realisation of savings and shift of budgets required by LLLB.

- **Leadership**

Including the strengthening of the strategic coalition of partners, development of governance arrangements to make the most of wider expertise residing in the Reference and Co-Production Groups, and forging stronger strategic and delivery links with related programmes.

- **Communications**

Including the further development and delivery of the LLLB communications strategy and plan, and the forging of stronger communication links between related programmes. The outcomes of the ongoing public consultation being delivered through the Healthier Together Programme will also inform the LLLB communication strategy.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

As indicated above, the Better Care Fund Plan is managed within the wider LLLB Programme. The governance outlined above applies.

Process

The process diagram in 2c is a useful reference point here. Commissioners city wide develop Care Models for specific cohorts that define the required outcomes. Providers then develop new delivery models to deliver against the Care Model outcomes. Each new delivery model is made up of a number of projects and initiatives, and providers draw down funding from the BCF pot to deliver these projects and initiatives by submitting a business case to their local Clinical & Integrated Care Board.

Once approved, the projects and initiatives are managed within the locality systems/economies, including the evaluation of the BCF investment. Evaluation also takes place citywide, led by the CWLG, who look to identify best practice, lessons learned and delivery models with the potential to be scaled up citywide. This, in effect, creates a learning system across the health and social care economy in the city.

Escalation of Strategic Issues

Risks and issues themselves related to the BCF get raised at the CWLG, which then has the option of escalating to the monthly executive group of the HWB. The executive HWB will then take the decision whether to escalate to the full HWB. The Financial Innovation workstream identified in section b) above is managed by finance leads drawn from the eight partners. This workstream provides the financial expertise to support the BCF and the wider programme, and plays a key role is mitigating and resolving risks and issues around the BCF.

Further development

Manchester has taken a decision not to put arbitrary timescales on when business cases to draw down BCF funding have to be delivered and signed off, after taking this approach previously and finding it limiting. The CWLG is currently working on new processes and procedures to support a more flexible business case development and approval process.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Approach to investment in LLLB priority groups

The LLLB programme has identified five priority population groups for which new delivery models have been designed / are due to be completed in 2014/15. Three of these have been developed (Adults with Long Term Conditions [LTCs], End of Life, Frailty / Dementia) with a further two still to be completed (Children with LTCs and Complex Adults).

Partners recognise that prior to implementation of new ways of working, business planning procedures and supporting Cost Benefit Analysis (CBA) techniques must be carried out to assess the feasibility of each NDM, in terms of quality and outcomes, patient experience, and cost effectiveness for the taxpayer.

North, Central and South Manchester CCGs are implementing the models within each locality in conjunction with a range of local providers. This leads to some variation with regards to the exact nature of individual schemes underpinning the overarching care models within each locality.

The detailed list of projects is available upon request if required. For the purposes of this return and to enable a degree of comparison between the localities within the Manchester Better Care Fund, the schemes and associated costs and benefits have been analysed at Care Model level.

Ref no.	Scheme
1	Frailty / Dementia
2	End of Life
3	Adults with Long Term Conditions
4	Adults with Complex Lives
5	Children with Long Term Conditions

5) RISKS AND CONTINGENCY

a) Risk log

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

Below is an extract from the LLLB Programme Risk Log as at September 2014

Risk Description	Existing Controls	Likelihood	Impact	Risk Score (L x I)	Response Actions (Mitigation)
The development of our business case for LLLB sits within the context of three overlapping and dependent programmes of work at a Greater Manchester level – 1) LLLB as part of the GM integrated care programme 2) Healthier Together the GM hospital services programme and 3) Primary Care development programme from NHS England. There is a risk that these three programmes are seen and delivered as separate independent pieces of work, and that objectives are not clearly aligned.	Existing governance - HWBB and EHWG.	4	4	16	The LLLB programme is being developed within the overall GM integrated care programme. The strategic aims and strategies for the three pieces of work are being aligned in Manchester through the agreed priorities of Manchester's Health and Wellbeing Board. The city wide leadership team for LLLB is particularly focussed on ensuring primary care is part of, and not separate to, the new community based care models. As we develop and deliver our communication and engagement plans for both our workforce and externally to our patients and customers, we will look to deliver a coherent and consistent message about what the changes mean for them, rather than the artificial boundaries of three interconnected programmes of work.

The structure of the health and care economy in Manchester is complex with three Clinical Commissioning Groups, four hospital trusts, the mental health and social care trust and Manchester City Council. There is a risk with this complexity that the LLLB strategy will be implemented and deployed differently through the three locality systems resulting in different service offers across the City.	Existing governance - HWBB and EHWG.	5	4	20	As we move from strategy to implementation in the LLLB programme it is essential that the overall strategic accountability for delivery of outcomes for Manchester people remains a priority for the Health and Wellbeing Board and its executive groups. The evaluation framework that we put in place for the programme must be developed to ensure that we can measure and evaluate progress across the whole system to ensure improved outcomes are delivered consistently across the city.
The financial picture for public services in Manchester over the next few years is extremely challenging with budget reductions for all statutory organisations in health and care services. There are clearly individual financial risks for each LLLB partner organisation which could result in service changes and instability for the medium and long term strategic aims of the programme.	Existing governance - HWBB and EHWG. Finance Steering Group.	3	4	12	It is clear that the increasingly difficult funding picture for public services mean that potential financial uncertainties for all LLLB partner organisations will need to be managed. The cost benefit analysis and ongoing management must continue to be co-owned by providers and commissioners. Funding and contracting arrangements put in place must be sustainable for all institutions and partners involved.

The strategic development of Living Longer Living Better in Manchester has been contingent on the relationships between commissioning and provider organisations in the City. The whole scale change of how health and care will be delivered in the future needs collaborative leadership from all sectors of the system. As Programme implementation activites get underway, there is a risk that these collaborative relationships will be strained or even break down as a result of strategic, legal and financial pressures, which could critically damage realisation of LLLB.	HWBB and EHWG. Links at CWLG level.	4	5	20	Over the next 6 months the governance structures that have been put in place to support delivery of the LLLB programme must be looked at and considered in terms of supporting the next five to ten years of sustainable change in our health and care economy. It must be ensured that we have appropriate forums and groups in place to tackle issues that arise and ensure implementation of our objectives is achieved over the medium and long term.
There is a risk that the financial planning being done by partners continues to be carried out in isolation, thereby resulting in contradictory expected financial outcomes across the system.	The Finance Steering Group chaired by Carol Culley (MCC) and Joanne Newton (CCGs)	3	5	15	Continued efforts by the Finance Steering Group to engender a sense of shared purpose and responsibility regarding financial planning, which needs to manifest itself in the Section 75/Pooled Fund agreement due in April 2015.
Given the complexity of the programme, there is a risk that the leaders on the CWLG fail to articulate both the progress and the ambitions of LLLB effectively to their own organisations and LLLB related governance bodies, thereby putting the credibility of the programme at risk.	Each partner organisation has LLLB related governance forums at which messages are disseminated.	3	5	15	The LLLB Strategic Plan to be delivered to the HWBB in September 2014 will be preceded by a period of consultation with organisational leaders, and will, as one of its objectives, look to improve the way objectives and progress are communicated.

The stability of the organisations partnering together to deliver LLLB, and the continuity of leaders involved in the Programme, is key to maintaining focus and successful delivery. Given the recent history of wholesale structural change in the Health & Social Care sector, there is a risk that this stability and continuity will not continue through the lifetime of the programme.	The CWLG provides the focus for organisational leadership.	3	5	15	Leaders on the CWLG will raise concerns and issues as soon as is practical to allow mitigation and contingency plans to be drawn up.
The capacity of the partner organisations to contribute to the delivery of LLLB is variable, given financial pressures and competing intra-organisations objectives. This puts the ability to deliver at scale and pace at risk.	A variety of resourcing arrangements across the partners.	4	5	20	CWLG leaders will continue to emphasise the importance of LLLB in their own organisations, and keep LLLB firmly 'on the agenda'.
Each partner organisation has inherent difficulties in managing the flow of patients across organisational and geographical boundaries that stretch beyond the Manchester city boundary. The programme itself is set up to deliver a new community based care system for Manchester only. There is a risk that competing boundary issues may adversely affect the focus given to Manchester services.	TBC	4	3	12	The CWLG will establish a working group over 2014/15 to address boundary issues in relation to LLLB
Clinical leadership is crucial to making LLLB work, particularly in terms of shifting resources safely and effectively from in-hospital to community settings, and ensuring the patient risk management culture shifts as a result. There is a risk that competing pressures on clinical leaders time - some are getting more heavily involved in GPPOs for example - may mean they deprioritise LLLB.	Clinical Boards and/or Integrated Care Boards exist in each locality. The LLLB Reference Group also draws part of its	4	4	16	CWLG leaders will continue to work with clinical leaders to engage them in the Programme and later in managing the external communications.

	membership from clinicians.				
To a large extent the success of a new community based care system depends upon the engagement with and involvement of GPs. Given competing pressures on GPs time - formation of new GP Provider Organisations (GPPOs), links into geographical clusters of other provider groups (Provider Partnerships) and the Primary Care Programme, there is a risk that the delivery of LLLB is put at risk if engagement with GPs doesn't improve.	The LLLB Reference Group draws part of its membership from the Primary Care sector.	4	5	20	1) Refresh of the membership of the LLLB Reference Group to engage better with GPs, 2) Stronger links forged between CWLG and the Primary Care Programme, 3) Continued engagement and involvement of GPs through the locality MDTs.
The locality system support structures and governance structures are still evolving, as are the relationships between commissioners and providers. There is a risk that these structures and relationships diverge significantly from locality to locality, thereby making the task of striking common ground to deliver LLLB that much more difficult.	TBC evidence of existing city wide forums to mitigate this.	3	3	9	CWLG leaders working together to identify best practice and align ways of working where applicable.
Demand for services is still rising across the system. There is a risk that continued increases in demand will outweigh the gains made from more efficient and cost effective services.	Each organisation pursues interrelated demand management strategies.	4	5	20	Closer links will be forged with Public Health Manchester and MCC universal services to broaden the prevention offer to residents.

The viability of the continued investment in new, innovative community based services is put at risk by an inability to recycle funds back into the shared investment fund. This inability could stem from new services inducing demand and/or tapping into previously unknown quantities of latent demand, thereby making it difficult to judge whether a) the new service is successful, and b) stop the new service and recycle funds.	The local and citywide governance structures set up around the BCF/LDF.	3	5	15	An evaluation framework at tool is currently being developed which will, as part of the wider framework, seek to identify where this is occurring. Similarly, evaluation mechanisms built into BCF business cases will also address this.
The viability of the continued investment in new, innovative community based services is put at risk by an inability to recycle funds back into the shared investment fund. This inability could stem from a lack of understanding and/or agreement on the way the funding should flow across the system in terms of spend and benefits accrued.	The local and citywide governance structures set up around the BCF/LDF. The Finance Steering Group chaired by Carol Culley (MCC) and Joanne Newton (CCGs)	4	5	20	The Finance Steering Group will look to map the way money flows across the system in 2014/15 as part of the development of the Section 75/Pooled Fund agreement..
The way patient safety risk is managed at present can often result in residents admission to hospital/residential care settings . The ability of the programme to shift activity from hospitals into the community requires a review of safety risk management.	TBC	3	4	12	This risk will be analysed further as more new delivery models are up and running in 2014/15, keeping in mind the need for strong support from clincial leaders.

The infrastructure workstreams the Programme has identified - IM&T, Estates and Workforce in particular - may well need a multi-agency approach that stretches beyond the scope of LLLB. There is a risk that the wider the delivery agenda for these workstreams, the less likely they are to deliver for the Programme in the timescales required.	Domain' working groups.	3	4	12	All workstreams will be refreshed on the Strategic Plan is signed off by HWBB in September 2014. This refresh will take account of this risk.
There is a risk that demands on workforce supply are not modelled effectively over the lifecycle of the programme, and therefore not addressed effectively, given the range of variables acting on workforce supply. These include: organisational transformational programmes resulting in workforce reductions; national workforce strategies led, for example, by Health Education England (HEE); and natural fluctuations in workforce supply, amongst others.	Workforce Domain	3	4	12	To be built into the work programme for the workforce domain.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Financial risk management will operate as follows:

i) Between care commissioners -

- Up to £2m has been identified across the three Manchester CCGs towards meeting the costs of the City Council's obligations under the Care Bill. This is being funded from the CCGs' allocation growth funding (the local estimate is currently higher than the nationally indicated value of £1.4m).
- It has been agreed by the Health and Wellbeing Board to set up a local development fund for the element of the BCF that relates to investment in new models of integrated care. Manchester City Council's share of the BCF plus additional funding has been included within the development fund to support investment through LLLB that reduces demand on social care activity. Any element of the development fund that is unspent in 2014/15 will be carried forward to be included in the pooled budget for 2015/16.

ii) At locality level between commissioners and local acute hospital providers -

- Resources will be set aside at locality level from health commissioners' contributions to the BCF, proportionate to the value of the 3.5% non-elective admissions reduction target. These funds will be set aside as a contingency to fund the costs of non-elective admissions that are not deflected through investments in alternative services.
- Using Part 2 of the submission template, it is estimated that this will amount to circa £3.2m. This represents the value of the 3.5% admission reduction target across Manchester (circa 2,100 admissions against the 'plan' baseline of 60,546). This will be adjusted in line with actual performance in 2014/15.
- Locality level risk resources will only be used to offset pressures arising from non-elective admission reductions that are not delivered within that locality (i.e. funds will not be used to manage pressures across other Manchester localities).
- Risk funds from non-Manchester CCGs' will not be sought for reasons of overall immateriality and practicality. Instead, locality CCGs will strive to deliver a higher volume reduction to offset this risk (as the volume is relatively small at up to 50-100 admissions per Manchester CCG).
- Acute hospital providers' local CQUIN schemes will be aligned to non-elective admission reduction targets to better incentivise providers to achieve a common goal (non-elective tariff payments do this to a degree but more incentive may be required, if possible and appropriate). Manchester will work with other GM CCGs to develop a relevant scheme, if possible.

Risk sharing in general to support the new community based care system as outline in the LLLB Strategic Plan is a live issue in Manchester. All LLLB partners are currently in discussions regarding the risk sharing options available to underpin the Section 75 agreement.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Context

The complexity of strategic environment described in section 2 requires the range of delivery programmes working within the health and social care environment to work in harmony. This raises challenges and opportunities around the following:

- Alignment of programme aims, objectives and timescales, particularly where programme activity is enabling other activities in related programmes.
- Different programmes working with the same citizen cohorts, which could lead to confusion and duplication, or collaboration and innovation depending on the effectiveness of programme leadership and governance.
- Contribution to financial outcomes, particularly in terms of having a defined programme contribution, a robust and transparent mechanism to calculate this contribution, and an agreed process between related programmes for rescoping financial contributions in response to changes in the strategic environment.
- Governance arrangements, particularly in terms of understanding 'where the buck stops' and ensuring organisations are spreading the programme governance load as evenly as possible amongst their senior leadership teams to mitigate against change fatigue.

The LLLB Programme is committed to working with other programme leadership teams to better align aims, objectives and outcomes to mitigate against the challenges identified above, and take advantage of the opportunities for inter-programme collaboration that present themselves.

Links to other initiatives

In addition to GM strategic programmes outlined in the strategic thread (section 2a and 4a), the LLLB Programme will need to align to the following programmes (table below) that are key drivers for change, are currently underway in the Manchester locality, and can support the delivery of BCF.

Initiatives/programmes that support BCF	How they support BCF/ Shared Resources	Communication / governance links
Development of LLLB Programme - (Local Vision Programme)	• The local vision programme is the overarching LLLB Programme, using a care modelling approach to developing and expanding integrated community based care (see section 3). • Through the detailed Care Modelling, and new delivery model co-production with providers we various BCF schemes have been	**Owner: LLLB City Wide Leadership Group (CWLG)** Comms/governance links: Manchester City Council Community Strategy / The Manchester Partnership. Local Integrated Care Boards (South, North, Central) and their

	developed for delivery. Shared programme office and governance, and enabling programmes of, infrastructure (estates, IT, Workforce).	individual community plans.

Personal Budget / **Individual Budgets'**	• Pilot mainstreamed as at April 2014. The government has already committed for a right to ask for a personal health budget for all those in receipt of NHS Continuing Healthcare.
	• Strategic links to MCC 'Individual Budgets' to be strengthened during remainder of 14/15.
	  ○ Synergies and areas of overlap between both brokerage models
	  ○ Looking at the implications of the Care Act for Brokerage.
	• Establishment of Joint MCC/CCG Brokerage Commissioning Strategy in 15/16.
		Owner: MCC
		
		Comms/governance links: Manchester City Council Community Strategy / The Manchester Partnership.
		
		City Wider Governance /LLLB CWLG communication strategy .

Challenged health economy	• Only South Manchester Clinical Commissioning Group sits within a challenged health economy. The South Manchester integrated Care Board is the mechanism for aligning programmes. • Linked governance structures to support alignment of delivery. • Shared evidence base/business case underpinning both programmes.	**Owner: SMCCG** Comms/governance links: South Manchester Integrated Care Boards, SMCCG 5yr plan, and local communication strategy their individual community plans. City Wider Governance /LLLB CWLG / LLLB communication strategy.
Mental Health Improvement Programme (MHIP)	• Redesigning mental health care in the city around the needs of patients and carers. • Mental Health workers are part of all three CCGs	**Owner: MHIP Programme Board** Comms/governance links: Mental Health

	approaches to community based care and neighbourhood teams. • Commissioned mental health services form part of a whole system that will contribute to the delivery of LLLB.. It is envisaged that services developed to meet the standards outlined within the MHIP care pathway specifications will also be integrated within the developing LLLB pathways for adults with complex needs and those with Long Term Conditions (LTC's). MCC commissioned well-being services, and how they will integrate with the mental health care pathway specifications will be centred on the development of the LLLB Healthy Adults care model and pathway development.	Improvement Partnership. City Wider Governance /City wide leadership team/ LLLB communication strategy.
Macmillan Cancer Improvement Partnership	• Improving cancer care with a focus on out of hospital care working with our Manchester CCG partners and Macmillan Cancer Support – Links to the End of Life Care model. • ***One locally commissioned service*** delivered across all CCGs/GP's in Manchester.	**Owner: MacMillan Cancer Improvement Partnership.** City Wider Governance /LLLB CWLG/ LLLB communication strategy
Review of Wellbeing and Lifestyle Services	• Redesigning services which help people get, and stay, healthy with Public Health Manchester. • Programme will underpin the self-care elements of all LLLB Care Models.	**Owner: MCC** Comms/governance links: Manchester City Council Community Strategy / The Manchester Partnership. City Wider Governance /LLLB CWLG / LLLB communication strategy.
CCG grants scheme	• Grants awarded to voluntary sector organisations for projects to reduce social isolation for older people with	**Owner: Manchester Alliance for Community Care**

	our Manchester CCG partners. • Shared voluntary sector resource across the city.	Comms/governance links: Manchester Social Isolation Partnership/ City Wider Governance /LLLB CWLG / LLLB communication strategy
Community services review – North and South CCG.	• A review of key community services with a view to refocusing existing service provision that fully supports integrated care and care outside a hospital setting. • Community services will be the cornerstone of the new delivery models, with learning from business case pilots being feed into the business as usual process of these services. Many of the services are shared across Manchester and some local CCG only.	**Owner: CCGs** Comms/governance links: Local Integrated Care Boards (South, North) and their individual 5yr plan/communication plans. City Wider Governance /LLLB CWLG / LLLB communication strategy.
Manchester City Council Children & Families Transformation Programme	• A rolling review of all services within adult and children's social care to enable the Council to meet funding challenges resulting from budget reductions. • This includes transformation work related to the Care Act.	**Owner: Manchester City Council** Comms/governance links: MCC partners and stakeholders in service delivery.

Within Manchester context, the LLLB programme sits within the wider framework and vision for the city as expressed in Manchester's Community Strategy, which is steered through the Manchester Partnership. Through all partners, public sectors, businesses, voluntary and community organisations and individuals, the Partnership works together to achieve three common priorities:

- **Growth -** Manchester is an engine of growth and has enormous potential to grow further, and to continue to create jobs and economic wealth. We will continue to build on our economic assets and strengths in financial and professional services; creative, digital and new media; advanced manufacturing and life sciences. We will also continue to support Manchester residents to develop the skills they need to access jobs and to benefit from the economic success of the city.
- **People -** Our priorities around growth will be linked to our ambitions to support and invest in people through the reform of public services. We will deliver services that foster aspiration, independence and resilience, and that open up pathways into employment through education and skills. This will help to reduce the demand on expensive, reactive services

- **Place -** We will continue to create and maintain neighbourhoods that attract, support and retain working people and offer a good quality of life for residents. We will have a focus on the needs of our different communities, ensuring that across the city our residents have access to clean, safe neighbourhoods with an attractive housing offer and the high quality range of services and facilities which are critical to the fabric of successful neighbourhoods.

By bringing together the complex agendas and partnerships that straddle these priorities, the Manchester Partnership is the mechanism by which LLLB programme and BCF schemes will be supported and aligned to the wider objectives for Manchester.

As outlines in section 4a, the LLLB CWLG and the Programme Management Office supporting the CWLG will be responsible for developing and managing links and interdependencies between initiatives and programmes, following best practice programme management approaches.

Housing and Technology

The LLLB Programme has recently strengthened links with the Housing sector. Two members of the CWLG sit on Manchester's Strategic Housing Board, and Housing sector representatives have been invited onto the LLLB Reference Group (see section 4b for governance linkages). A joint housing and health event is planned for 7th October 2014 at which the Chartered Institute for Housing have been asked to present/facilitate. This event will be attended by staff from health, social care and housing sectors and will provide an opportunity to further explore the links between housing and LLLB.

Manchester is a technologically ambitious city, and is constantly looked to upgrade its technology infrastructure to allow it to compete with 'Smart Cities' across the globe (Helsinki, Barcelona, Melbourne etc.) This work is being undertaken in collaboration with partners across public and private sectors, and the LLLB Programme in particular is linked into the Greater Manchester Academic Health Science Network in its efforts to develop the health and social care technology infrastructure.

At a more local level, the Information Management & Technology workstream described in section 4b is the forum through which all LLLB partners are collaborating on technology. Good progress has been made recently, for example, on developing information systems which share various clinical/care records in support of complex/vulnerable patients.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

CCGs have developed planning according to 'Everyone Counts' planning guidance which incorporates 5 year strategic plans and 2 year operational plans each with associated financial plans. The Manchester system has had strong alignment in its planning for a number of years and has a well established integrated care programme and, therefore, plans align well to national expectations and local system priorities. The thinking behind the BCF is congruent with existing strategic direction and, therefore, there is a natural synergy with regard to the plans. Clearly the annual planning process for years 14 – 16 followed the initial announcement of the BCF and was incorporated to operational and

financial plans. The BCF supports strategic direction relating to shifting the balance of resource to out of hospital care, improving quality of life for people with long term conditions as well as frail older people. The investments described are key service developments scheduled within plans for 2014/15 and 2015/16.

There are no risks relating to discrepancies in plans.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Currently the proposed 'Manchester Approach' to primary care co-commissioning is under discussion with the Greater Manchester Local Area Team (GMLAT). Whilst Manchester have been assessed as Ready Now, and Category Level 3, there is a lack of clarity on the specific roles and responsibilities and timescales. As such Manchester will refine how these new arrangements will support BCF in the next iteration of this work.

Nevertheless, there are already some aspects of co-commissioning taking place in the Manchester locality/across the three CCGs:

- The primary care demonstrator developments in Central Manchester resourced both by the CCG and the AT looking at increased capacity / access, services to support homeless patients and utilising the GP provider organisation to facilitate cross practice service delivery to meet the needs of local populations,
- The North Manchester Task and Finish Group to look at improving service delivery within practices (with a focus on actions across all commissioners of general practice on specific practices) with a view to improving outcomes for patients,
- SMCCG commissioning of same day access from general practice: In 2013, following negotiation with the Area Team to secure the funding designated for the Extended Hours DES, a same day access service was co-commissioned (funding LAT, contract management CCG). The purpose of this service was to support and resource General Practice to meet the demands presented by patients for Same Day Access, seeking to avoid the need for patients to present inappropriately to other specialist urgent care services. Within this co-commissioning arrangement the CCG could address local issues whilst supporting the delivery of the national ES programme,
- Identifying practice opening hours related to Christmas and New Year to align to local urgent care / access requirements and capacity needs,
- Discussions and developments associated with practice premises,
- The devolvement of monitoring of the national Avoiding Unplanned Admissions Enhanced Service to allow alignment and linkage to local integrated care locally commissioned services.

As a consequence of the above, there are CCG resources already being utilised to support co-commissioning, such as clinical leadership and management resource. Therefore in the first instance Manchester will ensure that teams share the expertise and learning that can support the delivery of BCF schemes.

In terms of engagement with primary care on the proposed Manchester Approach, significant work has been undertaken to engage CCG members practices, CCG Boards

and Patient & Public Advisory Groups (PPAGs), and through clinical leadership networks: all this is helping to define the benefits that could be achieved through primary care co-commissioning and so the specific roles, responsibilities and capabilities we need to deliver maximum benefit.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Social care is at the heart of the new delivery models for rolling out integrated health and social care services across the City. This reflects the need to ensure that Manchester people in need continue to receive the support they require during a time of increasing demand, changing demographics and fiscal constraints.

The 2011 national census showed that Manchester was the fastest growing city in the UK in terms of population. This population growth, combined with enduring challenges related to Manchester's poor health outcomes identified in section 3, serves to drive demand for adult social care in the city. Manchester has also made (and will continue to make) significant reductions in its social care budgets over the past three years, in line with national government expectations.

As a result, delivering social care services in the face of rising demand and budget reductions provides an ongoing challenge. It is crucial for health and social care partners to work together across the health and social care system to join up services in the community in order to reduce demand for hospital care and residential/nursing home care, and deliver services closer to home in a community setting.

Manchester will focus on ensuring that people stay healthy and well at home by intervening much earlier, promoting self care and maximizing people's independence and resilience. Health and social care integration at a community level, supported by BCF funding, will lead to the development of new local and citywide delivery models to which social care services will be central, thereby enabling a renewed focus on the causes of ill health.

Where services are assessed as required, these are delivered once, in a timely, planned and co-ordinated manner. The intention is to maintain current eligibility criteria at 'substantial', as defined by Fair Access to Care Services (FACS) criteria, and then meet the new national eligibility criteria agreed in the upcoming Care Act.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The Programme focus is upon shifting activity out of hospitals and residential/nursing homes by intervening to support people at the earliest opportunity and enabling them to remain well in addition to maintaining maximum independence. This includes supporting safe hospital discharge if a person has become unwell, providing alternative joined up care closer to home and preventing readmissions into hospital. As our ageing population

increases, we are working with our partners in health to identify frailty much earlier either in the community, if a patient arrives at A&E and in intermediate care. The role of social care will be pivotal to supporting and intervening with those who are identified as frail or are vulnerable and becoming frail in order to prevent them from relying on the health services.

New schemes

Examples of new integrated services with substantial social work involvement that have been implemented, supported by BCF investment, include:

- Multi-disciplinary integrated neighbourhood teams (see section 7dii) for more detail), operating from GP practices have been rolled out across the city, including the identification of a key worker. Over 1000 patient care packages have been reviewed as a result and early evaluation of the service has indicated a subsequent reduction in A&E attendance and non elective admissions in some of the localities,
- Health and social care integrated discharge teams have been developed to enable joint assessment of need and closer collaboration with health and social care community services such as reablement and intermediate care. In addition, there is a pilot in place which supports social work teams to work collaboratively across local authority boundaries; accepting different organisations assessments and ensuring the most appropriate response locally,
- Palliative care to all patients at end of life, supporting patients and carers with a 'hospice at home' model of care,
- A rapid response service for patients in crises to urgently assess their care needs in the community.

The new delivery models have, and will continue to create new and innovative ways of working which will change how social care services look and provide care in the future. A further example of this is that as a citywide provider of services, MCC is providing citywide teams to provide additional care and support as a result of seasonal resilience planning.

There is a growing recognition within the Programme that the provision of social care services is pivotal to achieving the activity shift out of hospital and as such social care services have been invested in using BCF funding with additional workers working in reablement, social work, assessment services; and additional investment in assistive technology.

Expansion of social work activity

One example of expanding the reach of adult social care will be via the emerging Carers Strategy which has been refreshed to align the priorities closer with Manchester's vision for all citizens to be more independent, and to be able fulfil their educational and employment potential. The Strategy takes into account the Care Act, which comes into force in April 2015 and ensures we meet the general duties within this:

- Promote individual wellbeing,
- Provide information and guidance,
- Prevent and postpone needs for care and support,
- Promote integration of health and social care services to meet needs,
- Promote diversity and quality in the provision of services.

A vital strand to the developing Carers Strategy is to focus greater awareness by GPs on the needs of Carers. Accordingly, MCC has developed a toolkit for GPs to support the early identification of carers in their work:

1. Identify more carers by setting up a carers' register,
2. Refer carers to local sources of advocacy, support and training including carers' centres or carers support group,
3. Refer carers for a carer's assessment,
4. Take account of carer's needs when allocating appointments and issuing prescriptions,
5. Take carers' needs into account when looking at waiting room arrangements,
6. Check the physical and emotional health of carers as regularly as possible, even if this means visiting the carer at home,
7. Ask patients who have carers if they are happy with their health information on their diagnosis, treatment and medication to be disclosed to their carer,
8. Ensure that there are leaflets and notice boards in the surgery to encourage self identification and notify them of the support available.

A review of information and advice services is also currently underway which will principally focus on a number of key areas:

- The creation of a Manchester Advocacy Hub to act as the focal point for referrals, match appropriate specialised advocates (e.g. IMHA or learning disabilities) to those in need and also encourage/promote self help solutions for friends and family. This will bring together a range of formally disparate services into one area improving knowledge and awareness of the service and enabling clearer referral pathways from health, social care and voluntary sector partners.
- Formally launch the Connect to Support website to enable citizens to purchase care and support services online and view available provision within the independent and voluntary sectors.
- Review the effectiveness of the small external brokerage service pilot with a view to further expansion and diversification to support all cohorts.
- Commission independent financial advisors on a framework agreement to advise citizens on their rights and how best to invest their money in social care solutions.
- Align web based content and information sources to ensure a seamless journey for citizens exploring available options.

A review of Respite Services is also underway which will seek to align the provision of a respite service to the city's draft All Age Disability Strategy which is currently out for public consultation. The proposal is to increase the capacity of respite for learning disabled adults and their carers, repurposing some of the poorer quality accommodation and improving the allocation of services through the development of a proposed new centralized placement team.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The health transfer for social care in 2015/16 is £12.219m of which £9.998m is committed for existing activity, £2m estimated for relevant Care Act duties and the remainder available for investment into health and social care integration as agreed with the HWB. Specifically CCGs have committed £1.73m from the BCF towards social care activity in the current business cases.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Over the past 12 months there has been a focus in Manchester on identifying and implementing efficiencies in the services MCC directly delivers to adults. Through these ongoing efficiencies MCC will be able to release staff to work in preparing for and implementing the Care Act, whilst recognising an ongoing pressure on staffing levels, training, and senior management capacity.

Work is currently underway to lay the groundwork for the implementation of the Care act, as follows:

- Carry out modelling of who future customers will be, how many, types of services and costs,
- Link with regional and national initiatives to communicate the changes and share best practice,
- Ensure the principles of market shaping and commissioning for the seven strands of well being identified are embedded into existing business as usual, C&F portfolio for Change Programme 2014-2017 and work with partners and the NHS,
- Ensure ICT support is commissioned to be able to set up new processes to support the outcomes of the Care Act,
- Identify impact of new regulations on demand for services especially bearing in mind criteria may be changed to include people with moderate needs,
- Identify any gaps which will necessitate new pieces of work,
- Estimate number of people who may need advocacy and ensure resources are available to facilitate this,
- Develop online pre assessment form to control demand,
- Understand impact of volume of new assessment and support planning requests for carers and self funders and arrange resources to facilitate these,
- Understand the consequences for widening eligibility criteria and model the impact this will have on costs going forward,
- Ensure new eligibility regulations when published are integrated into business as usual,
- Review carers services to ensure it is fit for purpose to implement outcomes from Care Bill,
- Agree changes required to social care electronic recording systems,
- Define workforce development needs and liaise with HR and ICT team to facilitate this,
- Develop the early help strategy and offer,
- Ensure financial systems are in place to support the introduction of the new Independent Personal Budgets and Care Accounts,
- Review the current audit and accountability processes of the IB system in place and ensure it's fit for purpose to meet the challenges of the Care Bill,

- Review HR resources to support an increase in assessment and support planning activity in the first year of implementation and ongoing review of increased number of people with eligibility and estimate future costs.

This work is being delivered through eight interrelated workstreams. The overall strategic lead for the implementation of the Care Act is the Strategic Director with statutory responsibilities for Adult Services. The structured governance approach sets out:

- The Care Act Board, chaired by the Strategic Director, will continue to be the forum for senior strategic oversight and meet on a monthly basis,
- In the initial stages – whilst we are responding to the consultation and awaiting the regulations in October – there will be eight workstreams,
- Whilst all areas are important, there will be significant demand on the Finance, Care Assessment and Commissioning workstreams due to the level of new requirements,
- One of the areas – specialist areas/approaches across GM – will be a stand-alone area in the first instance to discuss topics such as Prison Care Assessments in light of the agreed commitment to work collaboratively across the North West region via ADASS to share the cost of new requirements through the Care Act. Prison Care is one such example where there would be benefits in commissioning collaboratively across the region to enable a more specialist SW/Therapy Assessment and delivery of tailored solutions to meet identified care needs and improve outcomes; the challenges of meeting the needs of older prisoners with long term conditions cannot be underestimated.

The Board will play a key role in managing and leading:

- Resources – human, financial etc – to ensure that the appropriate level of resources are deployed to meet the identified regulations and requirements,
- Service improvements, particularly for areas such as policies and procedures – for example, one of the Care Act requirements is 'Managing Provider Failure'. This is already well embedded as part of Business Continuity Planning. MCC would use this opportunity to take stock of how well we perform in this area and the potential to improve. Any new policies and procedures developed as part of the work on the Care Act implementation would be signed off by the Board (but then may go onto other Boards or Committees as required),
- Receiving updates/progress reports from each of the workstreams; workstream leads will play a significant part in this work as it straddles all the adult social care responsibility area. Workstream leads will have a designated Board through which they can highlight and escalate progress, achievements, risks and issues,
- Oversight of the Risk Register,
- The reporting of progress via ADASS on what is happening in the NW region.

v) Please specify the level of resource that will be dedicated to carer-specific support

Planned resource of £541k in relation to assessments and support in addition to existing support provided from outside the BCF (for example, CCGs spend £80k specifically on carer support).

The Manchester Carers Form (MCF) is embedded within the LLLB governance structures, and during the last round of the BCF business cases LLLB Programme leads and MCF worked together to ensure bids included what the measureable outcomes for carers should were and the subsequent carer related resource implications.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

1. Estimated impact on social care in relation to assessment, social work, reablement and homecare from the new models of care included in the current BCF business cases, has resulted in CCGs committing £1.73m towards social care.
2. Business case for implementation of the Care Act approved = £2m
3. Planned reductions in residential and nursing activity from investment through BCF = £800k.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The Manchester health and care system has developed a business case approval process in order for innovations to be funded using the Better Care Fund (see the model in section 2). This approval process includes the national conditions, including seven day service and the associated clinical standards that need to be met, as key criteria for approval.

Across the city, a range of seven day a week community based services are already in place to support better access to services and safe and timely discharge home from hospital. Adult social care and reablement services are provided on a citywide basis and are available seven days a week.

As the adults community health services are vertically integrated with the local acute trusts, the services are often provided on the individual CCG footprint in order to ensure that place based service provision is most appropriate for local population need. The BCF has been used to fund a number of locality provided services to be available over 7 days per week across Manchester which include:

Early intervention at home
These are services that have been developed in localities to support people with an urgent health or social care need.

- **An Intermediate Care Assessment and Treatment Team (ICATT)** is an established 7 day service in Central Manchester which both expedites early discharges from hospital and prevents admissions. This service has established a robust and successful alternative to hospital admission by developing referral pathways with NWAS (North West Ambulance Service), Community Alarms, GPs, Active Case Management, District Nursing and other community services to respond to referrals for patients with urgent health or social care needs within 12 hours of referral. In addition, patients who attend A&E or the assessment areas of the hospital can also be referred to the team to support early discharge or prevent admission. The team also spend time in-reaching to the hospital and networking with nursing, medical and therapy staff to help to identify patients suitable for the service who may otherwise have been admitted. Patients are either managed in their own home or can be stepped up into an Intermediate Care community based bed.

- **A Crisis Response Service** enables patients who would traditionally have been admitted to hospital remain at home. The service is provided by a multi-disciplinary team including nursing, therapy, pharmacy and social care staff to provide a short term intervention (up to 72 hours). The service offers a one hour response time and receives referrals from GPs, community services, acute trusts and NWAS. The service is able to step patients up to bed based intermediate care and can gain access to rapid assessment, diagnostics and treatment at the North Manchester Treatment Centre (ambulatory care unit) on a day care basis. The Crisis Response Service is a component of a wider intermediate tier. BCF funding has also enabled

the opening of **nine enhanced intermediate care beds**. These beds form additional capacity for the intermediate care service and enables patients to receive intermediate care who would not previously have been able to benefit as their needs were too complex for the existing bed configuration.

- The South **multidisciplinary neighbourhood teams** are being enhanced through BCF funding to provide, amongst other things:
  - The core delivery of care plans will be provided over a 7 day period, with 24/7 provision.
  - An extended rapid response service that will support the management of people who become unwell in the community through providing a virtual ward concept.
  - A Community Consultant Geriatrician role, whose services align closely with the GP 7 day model, existing geriatricians, and the acute frailty pathway, to ensure the best use of resource.

- The **Community Alarms Service** operates citywide, and supports people to live safely at home and prevent hospital readmissions.

Supporting people with respiratory illness

- A new service that provides 7 day support on an **integrated pathway for patients with Chronic Obstructive Pulmonary Disease (COPD)**. Patients at high risk of hospital admission from COPD have been identified and managed as part of an integrated pathway between the patient's GP, COPD specialist team and the active case management service across Central Manchester. Access to the service is now 7 days a week and aims to manage patients in the community to reduce exacerbations and to respond to acute episodes of COPD to support the patient remaining at home whenever possible. The COPD team identify all patients admitted with COPD to assess for suitability for pathway management and support early discharge.

- A 7 Day **ASPIRE** (Acute Social & Primary Integrated Respiratory Care Engagement) Service was recently mainstreamed within South Manchester respiratory services. The Phase 1 concept tested by the pilot was for patients with a respiratory disease to be cared for within ASPIRE if they could safely receive their care closer to home instead of remaining in a hospital bed. For the pilot, the overall clinical accountability remained with the Clinical Director for Respiratory Services, UHSM and operated on the principle of shared care with the patient's GP. For the individual patient this remained with their consultant. Phase 2 provides a 'step up' facility for on-going chronic disease management for patients with respiratory diseases, supporting the avoidance of inpatient admissions.

End of life/palliative care

- **End of Life Care (EOL) in Residential Homes** is actively supported by the District Nursing Service, which operates 24 x 7. The team have engaged with residential homes in Central Manchester to deliver a training package aimed at care staff to support those patients at the end of their lives to die in their preferred place of care rather than be admitted to hospital. This project has achieved very positive outcomes and also provides support for care staff who have managed EOL patients in the residential homes as part of a case debrief.

- The South **Community Macmillan Specialist Palliative Care Team** is also being enhanced in 2014**.** Additional capacity and expertise has been dedicated to palliative

care and care at end of life care providing at home 7 days a week care and support for patients. This will be supported by the community MSPCT which will also include a 24/7 sitting service.

- In North Manchester, a new model of **end of life care** is being implemented which will enable improved care and more patients to receive care in their preferred place.

Collaboration with Primary Care

A number of services have been developed both with and often in Primary Care services.

- An **Additional Availability** service offers GP appointments to patients on weekday evenings and weekends from four host Practices spread across Central Manchester. It is provided by Primary Care Manchester Limited; a federation of the 35 Central Manchester GP Practices. Appointments are booked via the patient's own practice and the service has access to the patients GP records. The service commenced in December 2013.

- A **Responsiveness LCS** is provided in Central Manchester by 31/35 Practices and ensures practices meet a set of standards to respond to urgent primary care need, which reflect those achieved out of hours. This also ran from December 2013. In March 2014 a booking clerk based in A&E who was dedicated to making referrals to GP Practices was introduced. This began with appointments for follow-up after clinical consultation, but has recently extended to booking from Primary Care Emergency Centre (as an alternative to being seen there) and also direct from triage.

- Additional availability of routine **primary medical services** has also been developed extending availability to 8pm on week days and additional appointments for periods over the weekend. These appointments are a mix of routine as well as urgent appointments and are offered in four hub practices across Central Manchester.

- A **Seven day model** has been developed to prevent hospital admission for people aged over 65 with two or more long term conditions by deploying a GP as a senior decision maker at the front end of the University Hospital of South Manchester ED process.
  - Reduce admissions, with a KPI of an average reduction in Non-elective Admissions of 3/day during the 12 months of the service,
  - Reduce ED re-admissions / re-attendances,
  - Provide support and assessment as required and appropriate, for those patients identified by their GP as at risk of admission over the weekend,
  - Facilitate early supported discharge,
  - Provide timely and effective communication with the patient's own GP and any other relevant agencies.

  The service also provides support for the cohort patients outside of hospital including same day follow up (post hospital discharge), undertaking community visits and proactively supporting patients that may be at risk of admission. This model is being installed as one of Emergency Recovery Programme initiatives to reduce unnecessary admissions to hospital. It will also assist UHSM to improve performance around the A&E Access Target and improve performance such that annual performance benefits are realised.

- North Manchester has one practice already open from 0800-2000, seven days a week and the CCG are working with practices to develop seven day access for patients on a neighbourhood basis.

- The **Alternatives to Transfer** scheme enables lower acuity (following triage) 999 ambulance calls to be managed by a GP response. The scheme operates across the city and has enabled patients to avoid hospital admission and free up ambulance capacity to respond to higher acuity calls.

Summary

As can be seen from the examples above, Manchester is well on the way to establishing 7 day services across the city. However, Manchester recognises that this work now needs to be coordinated more effectively, and planned out in terms of expected patent outcomes and necessary resource shifts over the next 5 years, in line with the strategic Plan for 2020.

Commissioners have proactively identified planning gaps in their provider contracts. SMCCG for example has committed to develop an action plan with UHSM in 2014 following a gap analysis exercise against compliance with the 10 clinical indicators for 7 day working. Similarly, CMCC are working with CMFT to deliver a detailed strategy and implementation plan for delivery against the 7 day working clinical standards by December 2014.

The risks that Manchester has identified regarding the move to 7 day working are resource and demand related (risks captured in the risk log in section 6a), in that:

- Workforce supply and demand will be a factor, as will be the required culture change amongst the workforce,
- Demand management will be critical, in that the unexpected outcomes of 7 day working could be that avoidable demand is induced.
- The funding for 7 day services, and the required shift in in-hospital and out-of-hospital budgets will be a challenge given the complexity of Manchester's operating environment.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Joint working between Health and Social Care is outlined in the LLLB programme in relation to the associated cohorts which have been identified. There are also several other connections relating to joint working designed to deliver improved outcomes. These include working with families with complex dependencies, initiatives to improve the life chances of early year children and new statutory requirements relating to joint assessment for children with Special Education Needs and disability (Children and Families Act 2014).

As a result the systems and data sharing arrangements which underpin these

interconnected initiatives are complex and under development.

The Manchester health and social care system is committed to sharing data for the benefit of improved integrated care. The NHS number is the primary identifier used across health systems and this has now been adopted as the standard reference in the Framework-i Social Care Case Management System used by MCC. Currently over 80% of adult clients have a valid NHS number recorded by MCC and the intention is to continue the process of data collection and extend this to children (which will also assist in delivering as single assessment process for Children with Special Education Needs and disability as required by the Children and Families Act 2014)

In relation to the LLLB programme, an initial pilot of "Graphnet" (The Digital Integrated Care Record) is underway which is drawing together clinical and case management data from health and social care and is being used in each of the localities for patients managed by integrated teams. This will enable key workers to view data drawn from multiple systems when determining the appropriate care plan. The data feed from the MCC social care system is based on extracting data using NHS numbers provided by Health to be uploaded, via secure GCSX into Graphnet. The care plan function of Graphnet is also used as the agreed share plan by each of the locality integrated teams.

The extent to which this and/or other systems will be used will depend on the outcome of the pilot and further development of arrangements between public services as outlined above. For example, MCC are also piloting automated referrals from GP into the Social Care Case Management System. Further work on data extraction facilities that will support organisation business functions, and allow the provision of appropriate data extracts to Commissioners to their support organisations.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The LLLB partner organisations are committed to using systems that use Open APIs and standards.

Graphnet, the supplier of our Digital Integrated Care Record is an accredited ITK supplier. The hospital data flows into the integrated care record all use the HL7 international standard for the transfer of clinical and administrative data.

The Graphnet system also has the ability to extract coded primary care datasets from a wide range of GP Clinical Systems which means the digital integrated care record can cover all Manchester's GP Practices.

There is currently a programme in Manchester to implement the ITK accredited EMIS Web primary care clinical system across our GP Practices and some community care providers; this will provide two way access to patient records in real time for relevant NHS professionals.

The CCGs in Manchester are also implementing the PCTI ITK accredited system to transfer clinical correspondence (discharge information) between hospitals and primary care.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

LLLB partners have established a number of IG controls to support direct patient and the use of information for secondary purposes such as planning and monitoring.

Direct Patient

- The "Graphnet" (The Digital Integrated Care Record) has an auditable patient consent model. Every time a patient's record is accessed the clinician must record the fact that they have patient consent to do so and for what time period. The system records who, when and what was accessed and whether updates were made,
- As part of the care delivery process patients are systematically asked if they are willing to share their information across health and social care practitioners responsible for their care,
- An integrated care record is not created and shared with clinicians working as part of the multi-disciplinary care team without explicit consent. Written consent is captured and held within the patient's medical records,
- Data sharing agreements have been established between the health and social care organisations that flow data into the integrated care record. The agreements describe the data controllers, data processors, method of data transfer, frequency, data content, physical security arrangements, storage and data retention procedures,
- Information is not shared without explicit patient consent and processes have been established to handle the removal of consent.

Secondary Use

- Privacy notices and posters are displayed in care settings that describe how patient records are used,
- Identifiable data is only use for secondary purposes where patient consent has been obtained to do so. Wherever possible as per the Caldicott 2 recommendations anonymous information will be used,
- National secondary care data flows: The Manchester CCGs have complied with IG Toolkit standards and have become Accredited Safe Havens enabling access to weakly pseudonymised data to support secondary use purposes. The use of this information is strictly controlled and limited to small number of users and uses,
- Local data flows: weakly pseudonymised data flows into the local office of the Health and Social Care Information (Data Services for Commissioners Regional Office) are written into partner organisations standard contracts. These local data flows are fully pseudonymised by the DSCRO and made available to the CCGs for planning and monitoring purposes,
- The CCGs standard contracts with its care providers contain national data standards that need to be delivered; these contracts also include data quality improvement plans where required,
- Risk stratification: the DSCRO provides access to a fully automated 'closed system' that complies with NHS England's guidance.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

The LLLB Programme has segmented the city's population into different priority groups (see section 3 for further detail). The principles of joint assessment and accountable lead professionals will apply to a broad range of patients, not just those at high risk.

The most recent risk stratified data shows the city's population as follows:

Cohort	Number	Percentage of total
Very high risk	1829	0.3%
High risk	6709	1.2%
Moderate risk	21891	3.9%
Low risk	526041	94.5%
Total	556,470	

The city's practices are implementing the Avoiding Unplanned Admissions Directed Enhanced Service (DES) for patients in the top 2% at risk of hospital admission, with practices using the Combined Predictive Model risk stratification tool to identify at risk patients. In each of the city's CCGs, work has been undertaken to try and align the requirements of the DES with existing models of integrated working. Integrated multidisciplinary team models have been developed in each locality with broadly similar approaches.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

In Central Manchester, **Practice Integrated Care Teams (PICTs)** are working with patients identified as very high and high risk. The PICTs comprise a core team of community nursing, social care and primary care professionals who form the based of the multidisciplinary team but have access to support from mental health and more specialist skills. Each patient has a key worker drawn from the core team. All practices will be working to this model via the national enhanced service covering 2% of the population.

In North Manchester, the **North Manchester Integrated Neighbourhood Care (NMINC)** model is made up of three elements, based on the DE Long Term Conditions QIPP model:

- Identifying patients at risk of hospital through the use of a risk stratification tool,
- Integrated health and social care teams to proactively manage at risk patients,
- Systematic use of self care.

NMINC teams are based in four neighbourhoods and work with the GP practices in that neighbourhood. The NMINC model was based upon working with high and moderate risk patients but has recently been expanded to include very high risk patients to support patients covered by the Avoiding Unplanned Admissions DES. Teams comprise of GP, social worker, active case manager and/or district nurse. A recent business case has approved funding for mental health practitioners to join NMINC teams. Following an MDT

meeting, an agreed keyworker is identified who works with each patient to identify their goals and agree a care plan which including a plan for self care, an emergency care plan and where appropriate, anticipatory care planning. The programme is a time limited intervention of around 12 weeks.

In South Manchester **Enhanced Neighbourhood Teams (ENTs)** are working with moderate, high and very high risk patients who are aged over 65 with two or more long term conditions. The multidisciplinary ENTs comprise Community Nurse Practitioners, Mental Health Practitioners, Social Workers, GPs and Practice Nurses and are demonstrating positive outcomes for our most at-risk patients. The enhanced teams will continue to be based in the four SMCCG patches and will deliver the following:

- Fortnightly multidisciplinary team (MDT) meetings to be undertaken on a 5 day model (Monday to Friday) to support integrated care planning.
- Core delivery of multi-professional and single assessment care plans will be provided over a 7 day period, with 24/7 provision.
- Rapid response with support from the specialist teams consisting of a Community Consultant

Geriatrician, specialist nurses, therapists and allied health professionals.

Teams are deployed across four patches in the CCG and support the GP practices in their patch. A keyworker model is used with multi-professional proactive care planning (including the use of a frailty assessment tool). Each patient, in the risk-stratified patient cohort, is assigned a dedicated keyworker. Teams support patients in the cohort who are at the end of life and teams are supported by a range of health and social care services including consultant and GPSI support, rapid response and specialist nurses.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Currently, c3000 Manchester patients have agreed multi disciplinary care plans managed by the three integrated care teams. In addition, by the end of September, c7500 further patients will have care plans under the terms of the Avoiding Unplanned Admissions DES (i.e. the top 2% at risk patients not yet receiving care from the integrated care teams).

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

All LLLB partners are committed to the principles of co-production, involving residents throughout the design and delivery process. In designing a new way of working, partners will address the aspects of co-production, as outlined by the Social Care Institute for Excellence (2013). A Co-production Group, chaired by the Chief Officer of a local third sector carers' organisation, has been established within the programme to set and promote best practice in this area, and to monitor the development of new services to ensure that they are being designed in partnership with patients, carers and the public. This has established a five stage co-production process which maps across to the overall process for developing new services as below:

LLLB stage	Activity
Care Model development - research	Collate existing knowledge of need, preference and experience for each LLLB population cohort. For example, the Adults at the End of Life Care Model drew on 15 separate sources of customer feedback drawn from CCG intelligence, national intelligence, voluntary sector feedback and partner intelligence.
Care Model development	Identify co-production partners for each LLLB population cohort. Identify and develop relationships with additional community assets to support co-production. 2013/14 focus on local employers.
Care model / New Delivery model development	Identify process and methods for engaging with co-production partners for each population cohort. Deliver necessary engagement.
New delivery model development	Development of Patient Charter to identify standards for all emerging services
Monitoring of new services	Ongoing collation and reporting of feedback reported by providers as part of evaluation process

As well as the Co-production Group, the views of service users and carers have contributed to the development of the plan and the Care Models and New Delivery Models via a number of methods including:

- Healthwatch (members of the LLLB Reference Group),
- Partner organisations public engagement mechanisms (e.g. CCG Patient and Public Advisory Groups),
- Locality (North, Central, and South Manchester) based activity including public

events and planning sessions,
- Existing service user and carer feedback held by partner organisations,
- Intelligence gathered through partner organisations existing engagement mechanisms e.g. social media, membership schemes etc,
- A city wide resident feedback event in December 2013.

Future involvement

We are also fortunate that in Greater Manchester we are currently in the midst of the Healthier Together public consultation which is due to end in September 2014. As well as some questions about hospital reconfiguration, the consultation asks questions about integrated care and primary care and will produce a significant amount of useful information identifying what local service users and carers feel is important for future health and care services which we can then use to further develop our plans.

As noted in section 4b, organisations representing patients, service users, carers and the public are embedded into the Programme governance structures. The Co-Production Group in particular ensures the service user 'voice' is constantly fed into the Programme.

The criteria underpinning the business case process that in Manchester determines whether BCF funding can be released specifies the need for evaluation to take account of wider LLLB metrics related to patient experience and patient satisfaction (six measures in total). This ensures a consistent and regular flow of feedback into the programme development process.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Context

One of the key leadership challenges within such a complex Programme is to secure engagement and agreement amongst partners and stakeholders to make decisions about the future community based care system on a citywide basis, and to develop formal governance structures that facilitate this and the development and implementation of the plan. One of Manchester's strengths is that it has both Providers and Commissioners involved throughout the Programme governance structure, and has established forums and mechanisms for Providers and Commissioners to come together and actively collaborate on the development of the plan and achieving the Vision for 2020.

The Manchester HWB has overall and ongoing responsibility for the plan and this work, signing off the overall strategy and specific plans and implementation since 2012. The Board receives scheduled and regular Programme reports. The main Provider NHS Foundation and NHS Trust are Central Manchester NHS Foundation Trust (CMFT), Pennine Acute Hospital NHS Trust (PAHT), University Hospitals South Manchester NHS Foundation Trust (UHSM) and Manchester Mental Health and Social Care Trust

(MMHSC). All these Trusts have Executive members on the HWB.

Engagement & governance

The Programme Governance structure set out in section 4b enables ongoing engagement of Providers in all levels of the plans development. The **Citywide Leadership Group (CWLG)** provides the 'engine room' for the Programme and all Trusts have active membership at Senior/Director Level.

The **Reference Group** acts in an advisory capacity to the CWLG to ensure that the programme planning, design and implementation is sound. The membership of the reference group incorporates key people from within the health and social care system (clinical specialists, voluntary sector and community representatives) who are able to provide the programme with their perspective and expertise. All NHS Provider Trusts are represented.

The **Co-Production Group** has been established to make sure that people who use services, their families and carers have a chance to help design the changes. It will do this by making sure that all those who are responsible for different parts of the change involve people who can represent others like them (e.g. young people, older people, people with the same condition or disability, people from the same cultural group) in the design process. All NHS Trusts are represented to ensure the work of the co-production group remains aligned with the Programme plan.

In addition to the groups above there are a number of 'workstream' working groups that report directly to the CWLG. These provide the mechanism for all the NHS Trusts (and other eight core partner members), and other relevant partners and programmes, to collaborate on the joint design and delivery of solutions to support the vision for 2020. These workstreams are set out in section 4b.

In October 2013 a City Wide Provider Partnership (CWPP) was established membership made up of representatives from the following organisations:

- CMFT,
- UHSM,
- PAT,
- MMHSCT,
- MCC,
- Central Manchester GP Provider Organisation,
- South Manchester GP Federation,
- North Manchester GPs,
- Manchester Carers Forum,
- Manchester Health Watch,
- Go To Doc – Out of Hours provider,
- MACC,
- North West Ambulance Service.

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

The CWPP designed and proposed an overall template of how the design of new delivery models would be implemented. This included service design, partnership integration, system alignment, engagement (patients, carers, practitioner and the wider community), cost, impact, performance and enabling infrastructure including workforce, information and estates.

New delivery models for the early prioritised population groups were agreed and approved through all levels of the Programme governance structure. Implementation plans are being led by collaborative partnership forums across the three localities. The three acute/community NHS Trusts have a lead role in facilitating the coming together of the local providers in an appropriate structure for decision making. This leadership being based upon capacity and is not assume leadership of a new delivery model, nor future leadership of the partnership of providers. Provider Partnership Groups have been established and all Trusts are represented.

The Provider Partnerships are chaired by; Director of Operations in North Manchester, Chief Nurse in Central Manchester and in South Manchester by the chair of the GP Federation. This demonstrates that the partnership model has buy in, and is being led by, a range of different professional groups. The responsibilities of the Provider Partnerships are set out in the bullet points below and are key to ensuring the ongoing engagement of Provider Trusts and partners in the development and implementation of the plan:

- Determine the overall contracting mechanism of new delivery models and establish how partners wish to align themselves,
- Lead the collaborative design, development and implementation of the commissioners care models,
- Establish and maintain agreed performance management frameworks,
- Enable cultural change including partnership working that enables innovation and change,
- Maintain all accountabilities within the integrated governance structure,
- Maintain accountabilities within individual organisations through structures to their boards,
- Ensure provider contribution to development of any associated business cases preparations as appropriate to the commissioner requirements,
- Promote develop and maintain appropriate provider partnerships.

In addition to the Provider Trusts, membership is open to any organisations from the commercial statutory and voluntary and community sector which can enable the LLLB programme.

Across each locality in Manchester there is a strong collaborative approach adopted to maximise the input and engagement of an increasingly wider stakeholder group including; voluntary and community sector providers, acute trust providers, clinicians, GPs, patient representative groups, ambulance, out of hours providers, and subject matter experts and academics. In South Manchester for example, 70 representatives from across these organisations have been involved in the design groups, including Parkinson's UK, Age Concern, Alzheimer's Society, Manchester Carers Forum, and the Indian Senior Citizens Centre. In Central Manchester for example four locality 'engine rooms' have been set up to enable a wide range of community and provider groups involvement.

The LLLB Programme has a dedicated Communications and Engagement Strategy which recognises and enables interdependencies' with other related Programmes. LLLB is a city wide programme delivered in different ways in the three localities in the city – North, Central and South Manchester. Local Communications and Engagement plans, managed within the 'oversight' of the Programme Governance structure, ensure implementation.

Confirmation that the implications of the BCF delivery have been reflected in the Trusts' operational plans

The **Mental Health Trust** is a core member of the LLLB CWLG and the Chief Executive is a member of the Health and Wellbeing Board. The plans that have been developed for changes to the way in which services are delivered across Manchester have a broader scope than those specifically related to the BCF and the Trust, its staff and some of its services are an integral part of the planning and service development at CCG level. The MMHSCT 2 and 5 year plans are consistent with the aims and ambitions of LLLB and the work to ensure a greater integration of specialist mental health services with the programme is ongoing.

UHSM's operational plans and specifically, Integration Plans include objectives and implications of the BCF and LLLB. The Trust's CEO is a member of the HWBB to ensure alignment of plans and priorities across the City of Manchester.

UHSM's Two Year Operational Plan describes how the Trust works closely with CCGs and Local Authorities. Demand management is critical to ensure that demand does not overwhelm the available capacity at the Trust, particularly in winter on the non-elective pathway. The Trust has therefore been working with Clinical Commissioning Groups (CCGs) on deflection schemes designed to reduce non-elective admissions through integrated care neighbourhood schemes and the LLLB programme. These schemes are have involved extensive engagement with the CCGs and the Local Authority.

UHSM's five year plan details the Challenged Health Economy (CHE) programme, which has assessed a number of strategic options for healthcare delivery, including looking at provision of specialist services, elective day and inpatient surgery, and provision of major emergency services across the area covered by the SSP. The Trust is working closely with this programme and SMCCG to ensure that any proposals for reorganisation continue to support the provision of high quality, safe and sustainable services that patients expect and deserve. UHSM is committed to achieving the aims set out in this programme, which are consistent with Commissioner assumptions and the principles and requirements of the BCF.

Central Manchester CCG and CMFT have previously discussed 5 year commissioning plans that account for underlying (e.g. demographic) growth and the impact of admission avoidance schemes. These concluded that, over the five year period, the CCG was targeting a net reduction in emergency admissions and a net flat position in terms of absolute A&E attendances.

CMFT acknowledges these commissioner planning ambitions and has both offered support and participation in discussions/work intended to deliver them whilst also reflecting them, at a high level, in the Trust's Monitor Plan submission.

CMFT has not been able to plan at a detailed e.g. line by line level nor to be certain of the timing of any impact as this of course relies on the decision on which schemes are funded and the timing and success of implementation which part way through the first year of the plan is too early to yet fully ascertain.

(PAHT statement is pending)

ii) primary care providers

Please note, much of the background and detail of the engagement mechanisms and governance structures to which Primary Care Providers are a part of are included in 8bi) above.

Context

The main Primary Care Providers are considered to be General Practice, Local Pharmaceutical providers, Local Dental Service Providers and Local Optometry Providers. It is recognised that these are key providers in delivery of elements of the Programme and steps have been taken to enable their engagement. The Health and Well Being Board regularly meets with the Local Representative Committees (LMC, LPC, LDC, LOC) to enable their collective and individual engagement and involvement with the Programme on an ongoing basis.

Engagement

The Reference Group has a GP member from a CCG perspective and more recently representation from the LMC. Part of the work of the Co-production Group has been to undertake a mapping exercise of those groups/organisations that are stakeholders in the plan. Primary care providers are key stakeholders and their ongoing engagement is enabled by the Provider Partnerships including Primary Care Manchester (GP Federation) and GoToDoc GP (Out of Hours). A number of the workstreams have GP involvement from either a provider or commissioner perspective.

The recently revised LLLB Programme Plan, Care Models, New Delivery Models and the supporting BCF plan is progressed through all levels of the integrated Programme Governance structure. GP providers have been engaged with the design of the models and are actively engaged with elements of the plans' delivery. For example GP are members of the core Integrated Care teams and have been actively involved in the development of the models.

Confirmation that the implications of the BCF delivery have been reflected in primary care providers operational plans

In terms of incorporation of the BCF into operational plans primary care works to a national contract administered by NHS England. In areas where the CCGs and the council commission extended primary care this is incorporated into the delivery plans of practices. The opportunities of co-commissioning primary care will bring a more local connection to the provider side of primary care.

iii) social care and providers from the voluntary and community sector

Please note, much of the background and detail of the engagement mechanisms and governance structures to which social care, voluntary sector and community sector providers are a part of are included in 8bi) above.

Context

The main social care provider is Manchester City Council (MCC). Manchester is fortunate to have a wealth and diversity of voluntary and community sector providers. One of the key aspirations of the Programme is that this group of provider contributions is strengthened and expanded. It is recognised that they are key providers in delivery of elements of the Programme and steps have already been taken to establish a culture within the development and implementation of the Programme as a whole that makes this the norm and systematic. MMHSCT as a health and social care Trust has responsibility for some elements of social care for people with mental ill health and the engagement in LLLB and the BCF, is as in the previous section.

Engagement

Voluntary and community sector representatives are active members of the Health & Wellbeing Board, for example MACC and Healthwatch . The membership of the Reference Group incorporates key people from within the health and social care system (clinical specialists, voluntary sector and community representatives) who are able to provide the programme with their perspective and expertise. as does the Co-Production Group.

MCC is a core member of the LLLB CWLG and are actively engaged. Voluntary and Community Providers through, the reference group and provider partnerships, are invited to take part in Programme workstreams.

MCC, Manchester Carers Forum, Manchester Health Watch and MACC are all represented on the CWPP. Provider Partnership Groups all have social/voluntary/community Provider representatives, along with MCC membership.

The recently revised LLLB Programme Plan, Care Models, New Delivery Models and the supporting BCF plan is progressed through all levels of the integrated Programme Governance structure. Voluntary and Community sector providers have been engaged with the design of the models and are actively engaged with elements of the plans' delivery.

Confirmation that the implications of the BCF delivery have been reflected in the social care and providers from the voluntary and community sector operational plans

The LLLB Programme is central to the delivery of the strategic objectives of the Manchester City Council. A significant focus has been placed upon reform, and this programme is pivotal to MCC's ability to deliver the strategy

The LLLB Programme governance as a whole and as described above and in section 8bi actively seeks and enables the engagement of voluntary and third sector organisations. This will ensure these organisations are able to consider and assess the implications of the BCF delivery against their individual operational plans.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Five year hospital activity reduction targets were established across Manchester and shared with the three main acute providers in January 2014. Assumptions were refined prior to submission of the CCGs' two year operational financial and activity plans in April 2014.

The targets covered elective, non-elective and outpatient activity and reflected benchmarking carried out in relation to NHS Manchester's relative performance to peers to 31 March 2013 (pre-formation of the CCGs).

The top level target reductions were ambitious but reduced differentially at locality level due to the impact of assumptions surrounding the potential growth in population over the planning period to 2018/19. Planning assumptions were intrinsic to the CCGs' financial and operational plans submitted in April and June 2014, as well as the Healthier Together pre-consultation planning process.

Table 1 summarises the original activity targets, at both city and locality level:

			STRATEGIC TARGETS - Manchester CCGs (Gross % shift based on 2013/14 M8 Forecast outturn)				
			TARGET REDUCTIONS - 5 YEAR PERIOD				
POD	Agreed target shift %*	Indicative average prices	Target shift required 2014/15 to 2018/19	Indicative tariff cost of activity shift	North (All Trusts)	Central (All Trusts)	South (All Trusts)
		£	Activity	Indicative cost £	Activity	Activity	Activity
A & E	-10.0	£97	26,998	£2,606,679	8,927	11,415	6,655
EL	-8.0	£1,043	4,001	£4,172,506	1,501	1,243	1,257
NEL	-20.0	£1,733	11,098	£19,231,730	4,228	3,546	3,325
OP	-16.0	£101	78,998	£7,964,718	25,481	25,957	27,560
TOTAL - ALL CCGs			121,095	£33,975,633	40,137	42,161	38,797

* The targets are based on review of NHS Comparators information for NHS Manchester in 2012/13:

A more up to date summary of the planning assumptions specifically surrounding the metric for non-elective admission reductions has been shared with providers and included

in Part 2 of the BCF plan submission:

Non-elective admission reduction plans South Manchester CCG	15/16 Baseline
NEL Admissions Baseline	19,035
Deflections in opening plan	0
Additional Schemes	667
Year End Position	18,368
% Deflection vs Baseline	3.5%
North Manchester CCG	15/16
NEL Admissions	26,703
Deflections in opening plan	0
Additional schemes	1,335
Revised plan	25,368
% Deflection vs Baseline	5.0%
Central Manchester CCG	15/16
NEL Admissions	20,860
Deflections in opening plan	0
Additional schemes	1,439
Revised plan	19,421
% Deflection vs Baseline	6.9%
Cumulative	15/16
NEL Admissions	66,598
Deflections in opening plan	0
Additional schemes	3,441
Revised plan	63,157
% Deflection vs Baseline	5.2%

The aggregate deflection percentage in the above table is greater than the nationally suggested target reduction of 3.5%. However, this is because the CCGs have identified a higher volume of non-elective admissions in actual quarter one MAR data in 2014/15, as compared to quarter one MAR plans submitted in Unify in April 2014. Therefore ,the pre-populated 'plan' baseline in Part 2 of the BCF template for non-elective admissions is too low.

As the CCGs will be assessed in 2015/16 against their actual performance in 2014/15, the CCGs do not plan to resubmit a MAR plan, nor adjust the baselines figures within this return. Based on this assumption and the deflection schemes that are either recurrently in place or due to begin in the remaining part of 2014/15, the CCGs believe that a 3.5% reduction will be deliverable against the revised / actual 2014/15 baseline.

Due to stroke service reconfigurations expected to take place in 2015/16 across Greater Manchester, the CCGs' 2014/15 emergency admission baselines will not reflect an expected increase to non-elective non-emergency transfers that are included in the calculation of 'general and acute emergency admissions' (arising as a result of

repatriations of patients to the local non-primary stroke centres after initial admission to a primary stroke centre). As the impact of this service change is not reflected in either the current BCF planning template baseline, or the 3.5% target reduction volume, the CCGs' targets may need to be adjusted in this context, as more information becomes available.

The revised non-elective planning assumptions have been shared with providers to provide context to the BCF non-elective target reductions, with supporting detail about how each of the new delivery models contributes towards the locality targets.

Many of the schemes are currently in their early stages of implementation and remain subject to evaluation in terms of longer term investment.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

To be completed for final submission date.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Manchester
Name of Provider organisation	Central Manchester Foundation Trust (CMFT)
Name of Provider CEO	Mike Deegan
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	Pending
	2014/15 Plan	Pending
	2015/16 Plan	Pending
	14/15 Change compared to 13/14 outturn	Pending
	15/16 Change compared to planned 14/15 outturn	Pending
	How many non-elective admissions is the BCF planned to prevent in 14-15?	Pending
	How many non-elective admissions is the BCF planned to prevent in 15-16?	Pending

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	As stated elsewhere in the submission CMFT and Central Manchester CCG have previously discussed the 5 year commissioning plans that account for underlying demographic growth and the impact of the BCF schemes and other admission avoidance schemes. CMFT acknowledges these commissioner planning assumptions targeting a net reduction in emergency admissions and will continue our active and committed support to achieving the goals agreed jointly, over the five year planning horizon for this work.

2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	NA
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Evaluation and therefore detailed implications of the success of these schemes has not yet been fully possible, due to the timing of implementation which part way through the year of the plan is too early to fully ascertain.

Name of Health & Wellbeing Board	Manchester
Name of Provider organisation	University Hospital South Manchester (UHSM)
Name of Provider CEO	Dr Attila Vegh
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	Pending
	2014/15 Plan	Pending
	2015/16 Plan	Pending
	14/15 Change compared to 13/14 outturn	Pending
	15/16 Change compared to planned 14/15 outturn	Pending
	How many non-elective admissions is the BCF planned to prevent in 14-15?	Pending
	How many non-elective admissions is the BCF planned to prevent in 15-16?	Pending

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	UHSM and SMCCG have aligned assumptions in respect of 5 year commissioning plans that account for demographic growth and the impact of schemes falling under the BCF umbrella. These assumptions were considered as part of the Challenged Health Economy work on our respect 5 year plans. UHSM acknowledges that these plans target a reduction in emergency admissions. Through the integrated care governance structures that have operated successfully over the past 12 months across the wider health economy UHSM will continue its active and committed support to achieving the goals jointly agreed.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	NA
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The evaluation and therefore detailed implications of the success of these schemes has not yet been undertaken, due to the timing of implementation of the BCF schemes.

		Therefore, it is too early to fully determine success; however the investment is based upon commissioner and provider clinical commitment for success, and experience of other health economies in England.

Name of Health & Wellbeing Board	Manchester
Name of Provider organisation	Pennine Acute Hospital Trust (PAHT)
Name of Provider CEO	Dr Gillian Fairfield
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	17,172
	2014/15 Plan	16,373
	2015/16 Plan	16,063
	14/15 Change compared to 13/14 outturn	-799
	15/16 Change compared to planned 14/15 outturn	-310
	How many non-elective admissions is the BCF planned to prevent in 14-15?	1,438
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,335

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Pending
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Pending
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Pending

Name of Health & Wellbeing Board	Manchester
Name of Provider organisation	Manchester Mental health & Social Care Trust
Name of Provider CEO	Michelle Moran
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	NA
	2014/15 Plan	NA
	2015/16 Plan	NA
	14/15 Change compared to 13/14 outturn	NA
	15/16 Change compared to planned 14/15 outturn	NA
	How many non-elective admissions is the BCF planned to prevent in 14-15?	NA
	How many non-elective admissions is the BCF planned to prevent in 15-16?	NA

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The data provided as part of the return from Manchester is known to the Trust and senior Trust staff have been fully involved where discussion between the CCGs, their associated acute Trusts and the Manchester City Council have taken place. The Trust knows about the specific initiatives and interventions that have been or are being introduced in order to meet the relevant targets. The activity figures included in the return are for acute Trust activity. MMHSCT services have not had any revised activity figures as a result of the BCF submission.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	NA
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Consideration has been given to the impact on MMHSCT services as a result of the activity changes included in the submission and are directly supporting one of the Central Manchester Foundation Trust (CMFT) initiatives by providing clinical expertise to assist in the management of people with dementia.

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Manchester

Please provide:

Joanne Downs
joanne.downs@nhs.net

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Manchester

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	60,487
Change in Non Elective Activity	-2,120
% Change in Non Elective Activity	#NAME?

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	3,159,061
Combined total of Performance and Ringfenced Funds	#NAME?
Ringfenced Fund	#NAME?
Value of NHS Commissioned Services	13,853,000
Shortfall of Contribution to NHS Commissioned Services	#NAME?

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	15,546	30,291	44,990	60,487
Cumulative Change in Non Elective Activity	-487	-1,024	-1,558	-2,120
Cumulative % Change in Non Elective Activity	-0.8%	-1.7%	-2.6%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund	725,891	800,130	795,660	837,380

Health and Wellbeing Funding Sources

Manchester

Please complete white cells

	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
<Please select Local Authority>		
Total Local Authority Contribution	**-**	**-**
CCG Minimum Contribution		
NHS South Manchester CCG		11,638
NHS North Manchester CCG		13,436
NHS Central Manchester CCG		12,564
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**37,638**
Additional CCG Contribution		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**-**	**-**
Total Contribution	**-**	**37,638**

Summary of Health and Wellbeing Board Schemes

Manchester

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	-	-			
Community Health	10,123	13,853			
Continuing Care	-	-			
Primary Care	-	-			
Social Care	-	-			
Other	-	-			
Total	**10,123**	**13,853**		**-**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure
	2015/16
Mental Health	#NAME?
Community Health	#NAME?
Continuing Care	#NAME?
Primary Care	#NAME?
Social Care	#NAME?
Other	#NAME?
Total	**#NAME?**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	-	-	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	4,273	3,753	3,159
Other	-	-	
Total	**4,273**	**3,753**	**3,159**

<Please explain discrepancy between D44 and E44 if applicable>

Health and Wellbeing Board Expenditure Plan

Manchester

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**Joint % NH**	**Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Central Manchester - Adults with Complex	Community Health		CCG			NHS Community	CCG Minimum Contribution	183	183
Central Manchester - End of Life	Community Health		CCG			NHS Community	CCG Minimum Contribution	207	219
Central Manchester - Frail Elderly	Community Health		CCG			NHS Community	CCG Minimum Contribution	2,248	3,063
Central Manchester - Adults with long term	Community Health		CCG			NHS Community	CCG Minimum Contribution	1,035	2,027
South Manchester - Frail Elderly	Community Health		CCG			NHS Community	CCG Minimum Contribution	3,450	3,813
North Manchester - Frail Elderly	Community Health		CCG			Provider	CCG Minimum Contribution	1,529	2,173
North Manchester - Adults with Complex Needs	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	197	197
North Manchester - End of Life	Community Health		CCG			NHS Community	CCG Minimum Contribution	59	569
North Manchester - Long Term Conditions	Community Health		CCG			Provider	CCG Minimum Contribution	1,215	1,609
Total								**10,123**	**13,853**

Health and Wellbeing Board Financial Benefits Plan

Manchester

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Central Manchester - Adults with Complex Needs	NHS Commissioner	23	1,490	34,270	Based upon a business case assumptions for avoidable admissions	Service monitoring / QIPP reports
Reduction in non-elective (general + acute only)		Central Manchester - End of Life	NHS Commissioner	15	1,490	22,350	Based upon a business case assumptions for avoidable admissions	Service monitoring / QIPP reports
Reduction in non-elective (general + acute only)		Central Manchester - Frail Elderly	NHS Commissioner	136	1,490	202,640	Based upon a business case assumptions for avoidable admissions	Service monitoring / QIPP reports
Reduction in non-elective (general + acute only)		Central Manchester - Adults with long term conditions	NHS Commissioner	4	1,490	5,960	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		South Manchester - Frail Eldlerly	NHS Commissioner	1,252	1,490	1,865,480	Based upon a business case assumptions for avoidable admissions	Service monitoring reports / weekly monitoring of deflections
Reduction in non-elective (general + acute only)		North Manchester - Frail Elderly	NHS Commissioner	1,294	1,490	1,928,060	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester - Adults with Complex Needs	NHS Commissioner	124	1,490	184,760	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester -End of Life	NHS Commissioner	-	1,490	-	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester - Long Term Conditions	NHS Commissioner	20	1,490	29,800	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
Total						**4,273,320**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in non-elective (general + acute only)		Central Manchester - Adults with Complex Needs	NHS Commissioner	-	1,490	-	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		Central Manchester - End of Life	NHS Commissioner	173	1,490	257,770	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		Central Manchester - Frail Elderly	NHS Commissioner	278	1,490	414,220	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		Central Manchester - Adults with long term conditions	NHS Commissioner	66	1,490	98,340	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		South Manchester - Frail Eldlerly	NHS Commissioner	667	1,490	993,830	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester - Frail Elderly	NHS Commissioner	573	1,490	853,770	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester - Adults with Complex Needs	NHS Commissioner	124	1,490	184,760	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester -End of Life	NHS Commissioner	120	1,490	178,800	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
Reduction in non-elective (general + acute only)		North Manchester - Long Term Conditions	NHS Commissioner	518	1,490	771,820	Based upon a business case assumptions for avoidable admissions	Service monitoring reports
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
Total						**3,753,310**		

Manchester

Red triangles indicate comments

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**3,000**	**2,845**	**2,836**	**2,990**	**2,884**	**2,721**	**2,713**	**2,860**	**2,761**
	Numerator	15,546	14,745	14,699	15,497	15,059	14,208	14,165	14,935	14,532
	Denominator	518,245	518,245	518,245	518,245	522,148	522,148	522,148	522,148	526,407

Rationale for red/amber ratings

P4P annual change in admissions -2120
P4P annual change in admissions (%) -3.5%
P4P annual saving £3,159,061

Please enter the average cost of a non-elective admission[1]: **£1,490**

Rationale for change from £1,490

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Manchester	% Manchester resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Bury CCG	4,834	4,956	4,797	4,878	0.3%	0.1%	13	13	13	13
NHS Central Manchester CCG	5,435	5,235	5,108	5,419	93.7%	36.6%	5,091	4,903	4,784	5,076
NHS Heywood, Middleton and Rochdale CCG	6,805	6,261	6,134	6,418	0.5%	0.2%	34	32	31	33
NHS North Manchester CCG	6,381	5,907	5,955	6,223	84.8%	30.1%	5,413	5,011	5,052	5,279
NHS Oldham CCG	7,451	7,067	7,027	7,376	0.9%	0.4%	63	60	60	63
NHS Salford CCG	8,399	6,893	7,092	7,413	2.4%	1.1%	205	168	173	181
NHS South Manchester CCG	4,610	4,473	4,501	4,782	94.0%	28.7%	4,335	4,206	4,233	4,497
NHS Stockport CCG	9,551	8,188	8,327	8,623	1.2%	0.7%	116	99	101	105
NHS Tameside and Glossop CCG	7,108	6,907	6,849	6,821	0.4%	0.2%	30	29	29	29
NHS Trafford CCG	5,576	5,054	5,071	5,066	4.4%	1.9%	246	223	223	223
Total						**100%**	**15,546**	**14,745**	**14,699**	**15,497**

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

Manchester

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	770.2	698.5	627.3
	Numerator	375	345	313
	Denominator	48,430	49,392	49,894
	Annual change in admissions		-30	-32
	Annual change in admissions %		-8.0%	-9.3%

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	66.8	67.1	67.1
	Numerator	245	245	245
	Denominator	365	365	365
	Annual change in proportion		0.3	0.0
	Annual change in proportion %		0.5%	0.0%

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	666.6	695.7	507.2	586.3	666.6	695.7	507.2	586.3	666.6	695.7	507.2	586.3
	Numerator	2,677	2,794	2,037	2,375	2,700	2,818	2,055	2,392	2,719	2,838	2,069	2,410
	Denominator	401,609	401,609	401,609	405,097	405,097	405,097	405,097	407,975	407,975	407,975	407,975	411,023
						Annual change in admissions			82			*Annual change in admissions*	72
						Annual change in admissions %			0.8%			*Annual change in admissions %*	0.7%

Patient / Service User Experience Metric

Metric		Baseline 2012	Planned 14/15 (if available)	Planned 15/16
The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	*Metric Value*	7.3	7.2	7.1
	Numerator			
	Denominator			
Improvement indicated by:	Decrease			

Local Metric

Metric		Baseline [enter time period]	Planned 14/15 (if available)	Planned 15/16
Estimated Diagnosis Rate for People with Dementia	*Metric Value*	55.48%	67.02%	67.04%
	Numerator	2,383	2,957	3,020
	Denominator	4,295	4,412	4,505
Improvement indicated by:	Increase			

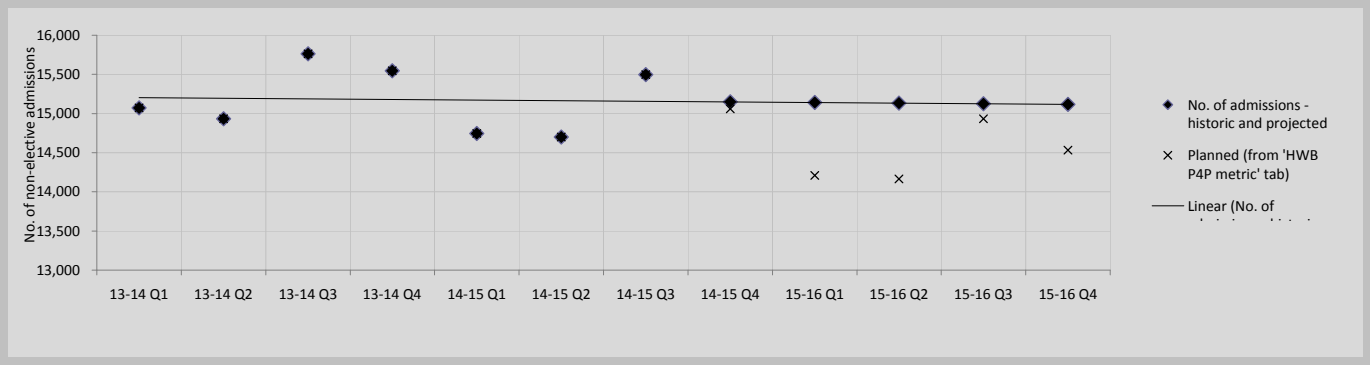
Manchester

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	15,070	14,935	15,765	15,546	14,745	14,699	15,497	15,149	15,142	15,134	15,127	15,119

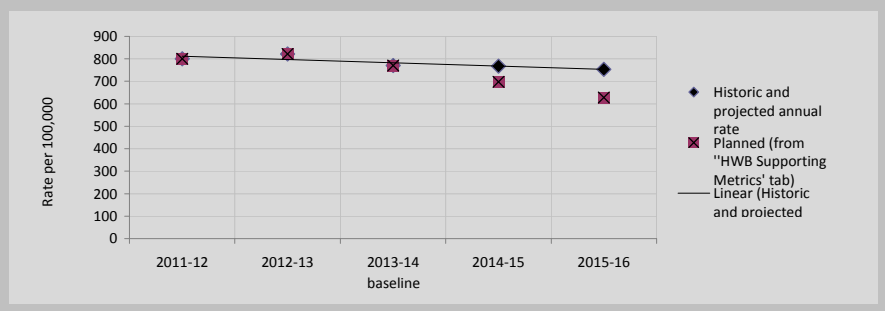


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,923.2*	*2,899.9*	*2,898.4*	*2,897.0*	*2,872.1*
	Numerator	*15,149*	*15,142*	*15,134*	*15,127*	*15,119*
	Denominator	*518,245*	*522,148*	*522,148*	*522,148*	*526,407*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

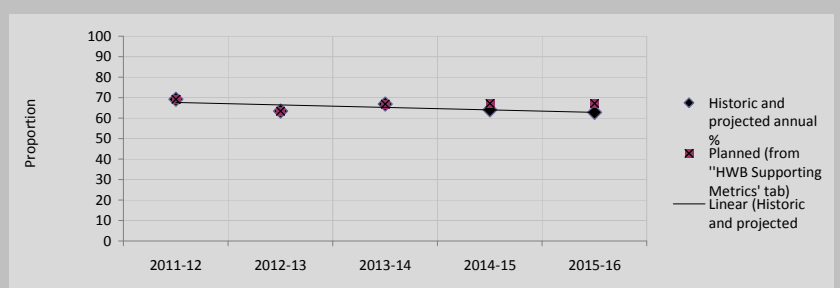
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	800	822	770	*768*	*753*
	Numerator	380	400	375	*379*	*376*
	Denominator	47,625	48,430	48,430	*49,392*	*49,894*



This is based on a simple projection of the metric proportion.

Reablement

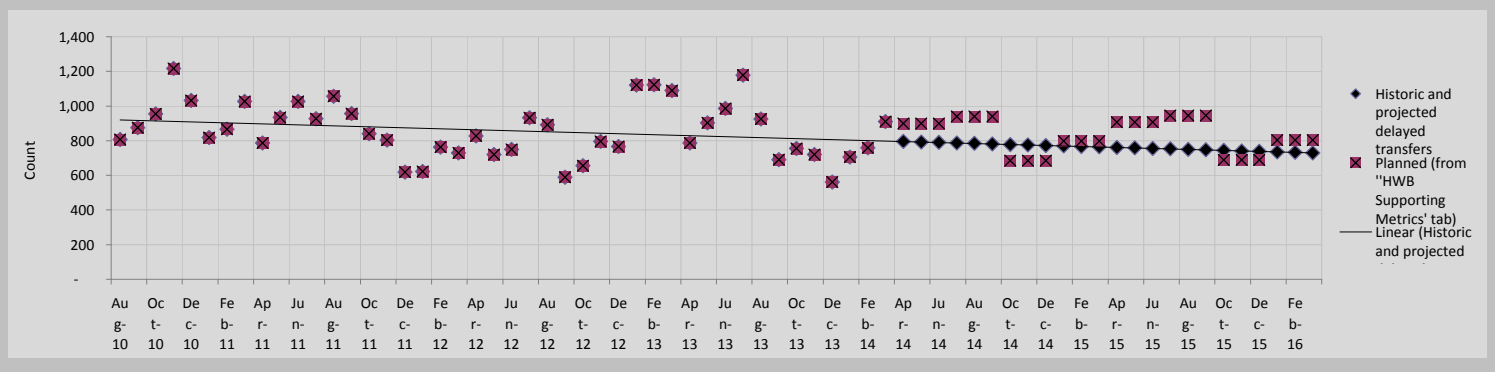
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	69.2	63.4	66.8	*64.1*	*62.9*
	Numerator	285	295	245	*234*	*229*
	Denominator	410	465	365	*365*	*365*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	807	876	955	1,218	1,032	818	867	1,027	786	935	1,026	928



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*587.0*	*580.7*	*574.4*	*564.0*	*557.8*	*551.5*	*545.3*	*535.0*
	Numerator	*2,378*	*2,352*	*2,327*	*2,301*	*2,276*	*2,250*	*2,225*	*2,199*
	Denominator	*405,097*	*405,097*	*405,097*	*407,975*	*407,975*	*407,975*	*407,975*	*411,023*

* The projected rates are based on annual population projections and therefore will not change linearly

HWB Financial Plan

Date	Sheet	Cells	Description
28/07/2014	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/2014	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/2014	HWB ID	J2	Changed to Version 2
28/07/2014	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/2014	a	AP1:AP348	Allocation updated for changes
28/07/2014	All sheets	Columns	Allowed to modify column width if required
30/07/2014	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/2014	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/2014	6. HWB supporting metrics	D19	Comment added
30/07/2014	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/2014	Data	Various	Changed a couple of 'dashes' to zeros
30/07/2014	5. HWB P4P metric	H14	Removed rounding
31/07/2014	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/2014	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/2014	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/2014	5. HWB P4P metric	H13	Apply conditional formatting
01/08/2014	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/2014	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/2014	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified
Version 2			
13/08/2014	4. HWB Benefits Plan	I61, I119, J61, J119	Delete formula
13/08/2014	4. HWB Benefits Plan	rows 119:168	Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
13/08/2014	4. HWB Benefits Plan	rows 59:108	Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
13/08/2014	3. HWB Expenditure Plan	rows 59:108	Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
13/08/2014	a	M8	Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
13/08/2014	HWB ID	J2	Changed to Version 3
13/08/2014	6. HWB supporting metrics	C11, I32, M32	Change text to *'Annual change in admissions '*
13/08/2014	6. HWB supporting metrics	C12, I33, M33	Change text to *'Annual change in admissions %'*
13/08/2014	6. HWB supporting metrics	C21	Change text to *'Annual change in proportion '*
13/08/2014	6. HWB supporting metrics	C22	Change text to *'Annual change in proportion %'*
13/08/2014	6. HWB supporting metrics	D21	Change formula to *=if(D19=0,0,D 18 -C 18)*
13/08/2014	6. HWB supporting metrics	D21	Change format to 1.dec. place
13/08/2014	6. HWB supporting metrics	E21	Change formula to *= if(E19=0,0,E 18 -D 18)*
13/08/2014	6. HWB supporting metrics	E21	Change format to 1.dec. place
13/08/2014	6. HWB supporting metrics	D22	Change formula to *=if(D19=0,0,D 18 /C 18 -1)*
13/08/2014	6. HWB supporting metrics	E22	Change formula to *=if(E19=0,0,E 18 /D 18 -1)*
13/08/2014	5. HWB P4P metric	J14	Cell can now be modified - £1,490 in as a placeholder
13/08/2014	5. HWB P4P metric	N9:AL9	Test box for an explanation of why different to £1,490 if it is.
13/08/2014	4. HWB Benefits Plan	H11:H110, H119:H218	Change formula to eg. *=H11*G11*
13/08/2014	2. Summary	G44:M44	Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab