Manchester
Integrated Care Partnership

Manchester Partnership Board	
Report of:	Warren Heppolette, Chief Officer – Strategy & Innovation, NHS Greater Manchester
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Item number:	3
Subject:	GM Strategic Financial Framework Development
Recommendations:	Manchester Partnership Board is asked to discuss the paper in the context of the city's priorities and approach to delivery and commit to engage on the translation of this analysis into local and system wide activity.

1.0 Background to the Financial Framework

The Greater Manchester (GM) Integrated Care Partnership (ICP) approved it's 5 year strategy in March. At the end of June the Partnership agreed and submitted the Joint Forward Plan (JFP) as the delivery plan for the ICP Strategy. It sets out the key actions to deliver our ambition against each of the six missions. It draws on a range of existing plans developed across the system and each GM locality. When submitting the JFP to NHS England, we recognised that further work was needed to strengthen our delivery plans to provide much greater detail on the approach to delivering the mission on financial sustainability.

The JFP recognised, therefore, the need for a Strategic Financial Framework (medium term financial plan). The analysis informing the Strategic Financial Framework underpins the JFP and provides the economic detail and mechanics for action for delivery.

It takes a longer term perspective on our health and care economy – building on the more immediate work to identify savings in the system which is responding to the current imperative to support financial recovery in this financial year.

It has the fundamental purpose of identifying the population-based approach opportunities to address our financial gap.

2.0 The Strategic Financial Framework

Methodology

The Strategic Financial Framework is developed via a four-stage approach:

	Understand baseline and "do nothing" forecast	Consider opportunities to improve health, performance and finance	Phasing and Investment	Reflect in financial framework
Population	**Understand place** • Segment population by age, condition and deprivation • Level of consumption of healthcare • Allocation growth • Spend on providers	1. Reducing the growth in prevalence and progression of ill-health 2. Optimising models of care to optimize total spend (across all settings) for each segment 3. Improving care for the most disadvantaged communities	• Identification of interventions and ROI • Non-recurrent investment to ramp up/double run services • Investment in data and digital capabilities	• Calculate the total allocation change including ICS and NHSE in the do nothing baseline • Optimise spend while improving population health and shift pattern of spend
Provider	**Understand provider** • Understand current activity and expenditure • Apply growth assumptions • Understand the underlying recurrent financial position of each trusts	1. Improve model of care to increase quality and flow (theatres, OP, discharge) 2. Pure unit labour productivity (skill mix, rota, bank/agency) 3. Procurement (drugs, medical consumables, nonclinical) 4. Estates (facilities, capital, etc) 5. Back office (IT, admin)	• Non-recurrent costs to support transformation • Any restructuring of costs to address a deficit • Investment in data and digital capabilities	• Forecast current underlying position for each provider • Understand the productivity gains that are required to address the underlying position

The framework covers:

- The demand for health and care services for the population of Greater Manchester over the next five years, given current trends, and how much it will cost the providers to deliver on those requirements;
- The opportunities to improve the health and care for the population of Greater Manchester to keep people healthier and manage their health needs better;
- How the change in population requirements will impact the demand on providers, and how this demand will be delivered efficiently;
- What the opportunities are for the efficient delivery of this care (provider-side);
- The investments required to realise these opportunities, and how quickly these benefits can be realised to meet national and local priorities;
- The impact of these opportunities on the Greater Manchester financial deficit, and whether there is any residual structural deficit and the drivers of it.

2.1 Headline Findings

The Strategic Financial Framework looks at keeping the population in good health, optimising the way healthcare services are used, and delivering care efficiently.

To support this, the Strategic Financial Framework has set out the baseline position, the ”do nothing” forecast, quantified the population health opportunities, set out the phasing and sequencing over time and considered the position of the 9 NHS providers. In short, this has outlined how a deficit of £570m today will grow to £1.9b in a “do nothing” scenario but can be addressed over time through a combination of population health measures and provider efficiencies.

GM ended 22/23 with a reported underlying financial deficit of £570m after removing nonrecurrent items. This will grow to £1.9b in 27/28 based on expected funding growth compared to activity growth and inflation.

This is driven by demographic growth of 0.4%, nondemographic growth of between 1.3 and 5% and tariff inflation of 1.8% per annum compared to activity growth and cost inflation of 2.9%. As a result, the financial position deteriorates.

To understand the health needs of the population we have used the Advanced Data Science Platform (ADSP) to access linked patient-level data on the GM population and developed a segmentation of the population. This shows that 29% of people in GM are not in good health and account for 79% of total costs. This can be reflected in the fact that a member of the adult population in good health cost £555 per capita whilst adults not in good health ranging from £1.7k per capita through to £84k per capita.

2.2 Responding to the Challenge

We have explored three opportunities to address the growing needs for healthcare:

1) reducing prevalence growth,
2) optimising models of care, and
3) addressing inequalities in access

Opportunity 1 addresses prevalence growth; we have examined the shift in population due to ageing and prevalence growth, whilst aligning this with the expected total growth in spending on providers. The analysis shows that the total spend on care will rise from £6,147bn to £8,488m based on a combination of population growth (£233m), age and prevalence changes (£1,381m), and tariff inflation (£724m). An opportunity of £249m or 16% of the impact of increasing prevalence and tariff inflation is proposed as the target to be delivered over five years starting in 24/25.

Opportunity 2 addresses variation in the model of care to support more cost-effective delivery. For this opportunity spend per capita across 9 segments of the population and 3 age bands, separated into Core20[1] and non-core20 were analysed. By controlling this way, it is possible to calibrate like with like in GM. Adding the overall opportunity in each segment highlights seven areas for focus: adults in good health, adults and older adults with multiple long-term conditions, children and adults with mental illness, adults suffering from homelessness or substance abuse and older frail adults. In total, this added, the opportunity stands at £1,294m, with over £1,025m concentrated in those seven segments.

Opportunity 3 focuses on addressing inequality. For this opportunity, the spend per capita difference between the Core20 and non-core20 in each segment, was analysed and showed that spend per capita is higher for the Core20 population in every Point of Delivery (POD) except for outpatients and elective. The savings were calculated if that gap was closed. 80% of this gap was assumed realisable to reflect some underlying differences in need. This leads to a £126m opportunity, of which £100m is in non-elective admissions as interactions are happening too late for these communities.

The feasibility of these opportunities is tested in two ways: by validating the scale of the opportunity externally and by testing the achievability of the opportunities with analysis of quality indicators.

- The external validation of benchmarking focused on urgent and emergency care because of the need for elective recovery on the one hand and the difficulty in benchmarking community and mental health given national data quality limitations. This showed comparable scale of opportunity in urgent and

[1] The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

emergency care when each place is benchmarked with its peers.

- The validation of quality focused on selecting a basket of quality indicators for each segment and analysing a normalised position in GM relative to the rest of the country and comparing this to GM. This in general showed the low spending places within each segment were generally consistent with at least average or better quality. It is clear there is high variation in the model of care for mental illness, however, a particular issue to consider is whether the opportunity is deliverable due to invisible waiting lists – both issues need to be better understood and addressed.
- We also looked overall at how GM benchmarks in quality indicators which show particular gaps in maternity and cancer and suggest that further action may be needed in these areas even though they do not deliver significant opportunity. This requires its own analysis and might represent an area where the system needs to spend more money.

To translate opportunities into potential spend/cost avoidance, each opportunity area has examined the evidence base for return on investment and timing.

- Opportunity 1 initiatives include smoking cessation, obesity management model and Semaglutide for advanced obesity care, which have a 5-year return on investment between 0.4 and 4.8;
- Opportunity 2 initiatives include CVD prevention and monitoring, dementia interventions and Respiratory disease, which have a 5-year return on investment between 1.5 and 3.7;
- Opportunity 3 initiatives include housing, food, transport and substance misuse, which have a 5-year return on investment between 1.5 and 11.6.

Further analysis suggests that a more targeted selection of initiatives would be possible if GM wished to pursue only high Return on Investment (ROI) initiatives.

Total investment requirements for each of the opportunities has been determined by ROI and this investment has been distributed to different settings of care using expert clinical advice. These have been phased on a straight-line basis, with 20% in the first year, and starting April to enable some initial benefits to be realised in that year (24/25).

The overall impact considers the population side and then providers. The reduction in provider demand through these opportunities will have a larger impact on cost and will help towards reducing the forecast deficit.

3.0 Next Steps

Additional work will need to be done to determine the level of provider efficiencies achievable and ensure alignment with the outputs of the current financial recovery work.

On completing the final outputs for the Financial Framework, the findings will be used initially to support the engagement and understanding across GM. This discussion and engagement will confirm the priority and phasing of initiatives. This in turn, should drive the development of our Operational Plan for 2024/25.

The implementation of the Operating Model should support us in these endeavours. It should remove some of the barriers to at-scale system change – including new approaches to decision-making, collective accountability, how money flows and system leadership development. Finally, it will support the discussion on the approach to implementation through proactive primary care, addressing unwarranted variation, tackling specific social determinants of health through provider collaboration.

4.0 Recommendation

Manchester Partnership Board is asked to discuss the paper in the context of the city's priorities and approach to delivery and commit to engage on the translation of this analysis into local and system wide activity