

**Manchester Health and Wellbeing Board  
Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 27 April 2016  
**Subject:** Manchester Health and Social Care Locality Plan Update  
**Report of:** Lorraine Butcher, Joint Director Health & Social Care Integration

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**Summary**

This is a covering report to support the presentation of the latest (and final) iteration of the Manchester Locality Plan for this review period, and briefly outline current developments and next steps.

**Recommendations**

The Board is asked to:

- Adopt the Locality Plan as the key strategic plan that underpins the radical transformation of health and social care provision in Manchester;
  - Note that two additional priorities have been added to the Plan:
    - Urgent Care,
    - Transforming Care;
  - Note the intention to keep the Plan under regular review with any changes to be reported to the Board; and
  - Receive reports on a quarterly basis on progress towards implementation of the Plan.
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**Board Priority(s) Addressed:**

<b>Health and Wellbeing Strategy priority</b>	<b>Summary of contribution to the strategy</b>
Getting the youngest people in our communities off to the best start	The Manchester Locality Plan aims to support the Health and Wellbeing Strategy by identifying the most effective and sustainable way to improve the health and social care of Manchester people.
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	

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**Background documents (available for public inspection):**

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

The Manchester Locality Plan (November 2015).

## **1. Background**

The background to the Locality Plan has been explained in detail to system leaders on a regular basis, most recently in the report to March's HWBB, in which developments since the first iteration of the plan in November 2015 were outlined. Given this, background detail will not be repeated here.

## **2. Status of the Plan**

The Locality Plan was endorsed by the HWBB in March 2016, on the understanding that it is the foremost strategy on the transformation of the health and care system in the city. This endorsement recognises the need to undertake substantial transformation work on the 'three pillars' described in the Plan – single hospital service, 'One Team', single commissioning system – to underpin the delivery of a high quality, financially sustainable health and care system.

The March 16 iteration of the Plan featured a revised list of transformation priorities, with the significant change being the addition of a priority on 'Urgent Care', recognising the need to raise the profile of this work. An additional priority has been added since March, 'Transforming Care', focused on the transformation of Home Care and Residential Care, to be undertaken in partnership with GM. The Plan appended to this report should now be considered to be the final version of the Locality Plan, albeit subject to periodic review.

The Board is asked to adopt the Locality Plan as the key strategic plan that underpins the radical transformation of health and social care provision in Manchester. In doing so, the Board is recognising the need to continue collaborating in an intra-organisational basis to achieve collective outcomes.

## **3. GM review**

The Plan is currently being reviewed by the GM health and social care devolution team, in the context of the other nine locality plans in the region, and the GM transformation fund. The Joint Director submitted a Plan Self Assessment on the 6<sup>th</sup> April, and has since received summary feedback. The overall review process is likely to run into June.

Along with establishing the rate of progress on transforming health and care across the region, this review process will also help clarify the support the city needs, and has access to, to enable the further development of the Plan and investment propositions.

## **4. Governance and reporting arrangements**

The Plan will be kept under regular review by the Joint Director, enabled by the monthly Locality Plan Programme Board. Changes of a significant nature – positive or disruptive – will be reported back to the Board following the Board meeting cycle.

Programme update reports will be presented to the Board by the Joint Director on a quarterly basis.

## **5. Next steps**

Feedback on the Plan from the GM Team will inform the development of the Plan over the next period.

Significant progress has been made since the turn of the year, supported by the recent BDO work, in developing the capabilities that will enable a more granular understanding of need, interventions and outcomes, and the links between all three. This work will continue, with the aim of better understanding the specific changes needed over the period of the Plan to achieve the city's ambitions.



## **Greater Manchester Devolution of Health and Social Care**

# **April 2016**

## **Manchester Locality Plan – A Healthier Manchester**

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## 1. Introduction and Overview

- 1.1 'Taking Charge of our Health and Social Care in Greater Manchester' is the key strategic plan determining deployment of devolved control over health and social care budgets, a combined sum of more than £6 billion. For the first time, health and social care will become integrated and local people will be taking charge of decisions on the health and care services for Greater Manchester.
- 1.2 This Manchester Locality Plan details the transformation ambition for health and care services in the City as part of the Greater Manchester Plan. Importantly, Manchester needs to contribute significantly to the population health outcomes articulated in the GM Plan if it's ambition is to become a reality.
- 1.3 The Manchester Locality Plan - A Healthier Manchester - details the strategic approach to improving the health outcomes of residents of the City, while also moving towards financial and clinical sustainability of health and care services. It builds upon the Manchester Strategy which sets a long term 10 year vision for Manchester's future and how it will be achieved. The Manchester Strategy is underpinned by the Joint Health and Well Being Strategy, the city's overarching plan for reducing health inequalities and improving health outcomes for Manchester residents. The Locality Plan sets out how the transformation will be delivered. The plan will be supported by growth, development of skills, education, early years, improved housing and employment. Partners working across Manchester, in the public sector, in businesses, in the voluntary sector and communities, all have a role to play in making Manchester the best it can be (Appendix 1).
- 1.4 Seven principles of change underpin the Locality Plan:

**Principle one** - People and place of Manchester will have priority above organisational interests;

**Principle two** - Commissioners and providers will work together on reform and strategic change;

**Principle three** - Costs will be reduced by better co-ordinated proactive care which keeps people well enough not to need acute or long term care;

**Principle four** - Waste will be reduced, duplication avoided and activities stopped which have limited or no value;

**Principle five** - The health and social care system is made up of many independent and interdependent parts which can positively or adversely affect each other. Strong working relationships will be developed within the system with clear aims and a shared vision for the future;

**Principle six** - There will be partnership with the people of Manchester, the workforce, voluntary and community organisations;

**Principle seven** - The partnership will work to safeguard children, young people and adults, enhancing their health and well-being and protecting the rights of those in the most vulnerable situations.

- 1.5 This is an ambitious and demanding Plan which reflects the shared commitment and vision of the Manchester Clinical Commissioning Groups, Manchester City Council, the acute hospital trusts, Central Manchester Foundation Trust, University Hospital of South Manchester, Pennine Acute Hospital Trust and Manchester Mental Health and Social Care Trust. The Plan continues to form and will be subject to review as further work by commissioners, and with stakeholders, the VCFS, Health Watch informs the safe and good quality delivery of services.
- 1.6 The Locality Plan is the **transformation plan** for health and care integration for Manchester. It contains **3 key pillars** which together will drive the radical transformation of health and care services to the residents of Manchester. These are mutually dependent and are:
- **A single commissioning system** ('One Commissioning Voice') ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services. This approach will integrate spending across health and social care on high cost/high risk cohort, reducing duplication of service delivery and fragmentation of care;
  - **'One Team'** delivering integrated and accessible out of hospital services through community based health, primary and social care services within neighbourhoods. Through the combining of resources residents will get integrated services, resulting in improved outcomes (holistic needs addressed) at reduced cost;
  - **A 'Single Manchester Hospital Service'** delivering cost efficiencies and strengthened clinical services, with consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the City.
- 1.7 The Manchester approach will ensure that:
1. There is a clear focus on place, the needs of residents, and not organisational interest;
  2. The City continues to be at the fore of clinical excellence and continue to attract world leading clinicians;
  3. There is a stronger service offer to residents ensuring their health and care needs are addressed earlier, that they are encouraged to take responsibility for their own well being, and that, when they need access to more specialist care that that is available to them and affordable; and
  4. Front line health and care staff are professionally fulfilled in the demanding roles that they undertake.

- 1.8 Importantly the commissioners and providers of health and care will come together to ensure duplication and fragmentation of service provision is removed, that unnecessary costs are avoided, and that our clinical leaders shape the model of delivery most suited to meet the needs of residents in Manchester ensuring that in future they get the ***right care, at the right time, in the right place.***
- 1.9 This Plan demonstrates the continued commitment of partners to continue to deliver the highest levels of clinical excellence, and to be a City which continues to attract investment in health sciences as part of its growth strategy.

### **Why do we need this Plan?**

- 1.10 It is clear that the sustainable future of health and social care depends on ***partnerships, collaboration and working together.*** The way forward is clearly one of 'connecting care' across the different sectors of health and care: between family doctors and hospitals, physical and mental health and health and social care. Clinical and financial sustainability will be secured through more innovative commissioner and provider arrangements, where the commitment to 'place' rather than organisation takes primacy. Locally the main aim is the 'one team' philosophy and ethos that all Manchester partners support.
- 1.11 Although there have been some local successes in changing the way services are delivered, more needs to be done to ensure services consistently meet the needs of local people, are ***clinically safe*** and are ***affordable***. Often services are fragmented, reactive and difficult to access. Staff can sometimes find it difficult to meet the needs of the people they support in the way they would like and feel is necessary.
- 1.12 Importantly, health outcomes for Manchester's residents remain among the worst in England. Whilst the City has transformed in terms of economic growth and infrastructure people's health and wellbeing have not prospered. Good health is key to ensuring residents achieve their full potential and benefit from the economic growth and transformation taking place in the City. It is key to reducing dependency and ***unlocking the potential of the community*** to live well and contribute towards the City's growth.
- 1.13 High rates of smoking, drinking and poor diet are key factors in a cycle of ill health that compares unfavourably to other major cities. Manchester is the 4<sup>th</sup> most deprived area in the UK with over 36% of children living in poverty and life expectancy for men and women is lower than the national average. The levels of adult and child obesity, teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery, smoking related deaths, hip fractures, sexually transmitted infections and TB are all worse than the national average. Manchester has some of the worst outcomes for stroke, cancer and heart disease.

## Our Services are Under Pressure

- 1.14 Importantly our local services are experiencing levels of demand that are unsustainable and the whole system is not working well together to better meet those demands. Critically:
- Primary care and specifically GPs are under pressure and over the next 5 years a number are expected to retire;
  - Compared to other regions of England, the North West Ambulance Service takes the highest percentage of patients to A & E and the second lowest percentage of calls are resolved with phone advice;
  - Approximately 80% of A & E attendances are walk in presentations;
  - Even though Manchester has a relatively young population, the over 65s make up a disproportionately high percentage of non-elective admissions to hospital;
  - Compared to the national picture, emergency admissions of patients are high. Over the past 3 years there has been an 11% increase in admissions to Central Manchester University Hospitals, and a 13% increase in admissions to the University Hospital of South Manchester.
  - There are high levels of admissions to residential and nursing homes;
  - The wider urgent care system in Manchester is not functioning effectively leading to huge demand and pressure on the acute hospitals.

## Financial Challenges

- 1.15 Alongside these major challenges locally there will be less resources available to commission the services required to address these health and care challenges. In total Manchester spends £1.1bn on health and social care services, excluding specialist services. The strategies and priorities described in this Plan represent Manchester's health and care partners' agreed approach to managing a predicted 'do nothing' deficit of £284m by 2020/21. A summary financial plan for the 5 years to 2020/21 has been projected for Manchester, taking account of pressures and demographic changes over the period, together with the estimated changes in resources for health and social care. The deficit originates from net estimated challenges across health and social care of £163m and £121m respectively (Appendix 2).
- 1.16 It is recognised that a deficit of this magnitude will only be avoided through strong commissioning across the 5 commissioning organisations, and by strong partnership working by providers. Providers have agreed to the principle that the delivery of the transformation programmes will enable a shift in resources between hospital and community settings.
- 1.17 Applying the Greater Manchester savings opportunities identified within the draft CSR submission to Manchester, indicates that Manchester has a potential position (scenario 1) which converts the significant 'do nothing' deficit of £284m to an approximate break even position. However, the alternative scenario 2 to date (**and subject to further review**) currently indicates a deficit of £149m remains.

<b>Benefits Analysis Summary by Scenario by 2020/21</b>	<b>Scenario 1</b>	<b>Scenario 2</b>
	<b>£m</b>	<b>£m</b>
Do nothing gap 2020/21	<b>284</b>	<b>284</b>
Additional Funding	-154	-44
Net Locality Transformation Plans	-81	-81
Provider Cost Improvement	-94	-34
Estate and Back Office Transformation	-34	-34
Other	58	58
<b>Closing position (Surplus)/Deficit</b>	<b>-21</b>	<b>149</b>

## Ambition

1.18 Our ambition is that by 2021 residents of Manchester will:

- Benefit from a transformed, integrated health and social care system, in which they receive health and care interventions which are joined up, of high quality, and are affordable;
- Be supported and encouraged to do what they can to remain healthy;
- Live in a City which encourages them to make the right choices;
- Ensure that when they need access to more specialist support they receive it in the right place at the right time appropriate to their needs and wishes.

## How will this be achieved?

1.19 This will be achieved by transforming how health and care services are currently commissioned, delivered and paid for. The integrated commissioning and delivery of services will shape a model of care which:

- Helps to achieve better and health and wellbeing outcomes for the residents of Manchester;
- Reduces variation in quality and improves consistency of approach
- Promotes independence and champions prevention;
- Works with the local communities in the places we deliver services;
- Works more closely with carers, voluntary and community sector groups recognising the valuable contribution to care that they make;
- Delivers effective and responsive services as close to a person's home as possible;
- Ensures that residents have access to high quality specialist services when they need it;
- Be clinically and financially sustainable.

1.20 To enable this to happen, the CCGs and City Council have agreed an ambition to pool budgets totalling indicative sums of £378m over the medium term, including approximately £168m from the City Council and £210m from

the CCGs. For 2016/17 the expansion of the pooled budget will cover the first phase of building the integrated care model – One Team – and will be £89m.

- 1.21 The key principle behind pooling resources is to drive transformational change, and deliver the ambition contained in this Plan. Future financial arrangements will support integration and be very different from previous experience. In particular:
- Access to transformation funding via GM, together with access to pooled resources, will enable investment in the initial phase of implementing new care models for the future;
  - Investment into the new care models will be tracked in terms of impact on activity levels in the acute sector and in the residential care sector in particular. That evidence will be used to justify reduced spending on those services. The reduced spending will be captured and transferred to replace the temporary investment monies and to support the scaling up of the new care models;
  - Transition will happen over a 4 year period so that existing business as usual models of care are gradually replaced with the new integrated models of care.
- 1.22 A transformed service will result in a shift of resources from the acute sector (reacting to poor health) to investment in community based (and preventative focussed) health and care support.

### What will be different?

- 1.23 **Firstly**, there will be a stronger emphasis upon **prevention** and **self care** with support being mobilised to focus upon promoting well being. The people of Manchester will be supported to live well and stay well through a stronger approach to the public's health.
- 1.24 **Secondly**, those sections of the population most at risk of needing care will have access to more **proactive care**, available in their **local communities**, and delivered through one of the 12 Integrated Neighbourhood Teams that are currently being formed. This model places primary care services at the heart of an integrated neighbourhood model of care in which the ambition is for Primary Medical Care Services to be co-located with community teams including Community Pharmacists, AHP's, Community Nursing, Social Care Officers, Intermediate Care teams, Leisure and health promotion teams, Ambulance teams and 3<sup>rd</sup> sector teams within fit for purpose estates and with a link to educational and employment teams. The teams will be multi-skilled, crossing traditional boundaries and remits and sharing information across a common IT platform or interoperable IT platforms to agreed standards and protocols.
- 1.25 **Thirdly**, for those residents who need access to more specialist acute care, this will be available through **A single Manchester Hospital Service**, shaped

by clinicians within the hospitals, enabling resources across the hospital sector to be more effectively deployed. Critically, no medical services will be lost to Manchester. Rather, delivery of hospital services will be strengthened, through more effective commissioning and delivery arrangements.

1.26 Underpinning this approach is a unified commissioning system, with the 3 Clinical Commissioning Groups and City Council combining their resources and more effectively **commissioning for the outcomes** that they wish to see delivered. In other words, rather than purchasing individual episodic care and treatments from particular providers, the focus is on the providers to collaborate, combine their own resources to deliver services which will more effectively address the holistic needs of the individual and improve the health outcomes for the residents of the city.

1.27 In summary this will mean the following:

- More people will live active lifestyles and take responsibility for their own wellbeing;
- Residents will be supported to live independently within their own homes/communities for as long as possible and fewer people will be admitted to residential and care homes;
- Provision of social care services will continue to be supported;
- People will be admitted to hospital if their needs require it and they cannot be addressed by integrated services out of hospital and in the community;
- There will be a joint approach to assessments and care planning;
- There will be 7 day access to primary care;
- There will be fewer non-elected admissions to hospital;
- People will be discharged from hospital when their needs have been addressed and delays in being discharged from hospital will be reduced;
- Redesigned and more accessible urgent care services will be provided in the community;
- Hospitals will offer fewer overnight beds and more patients will be treated as day cases.

### **How will this be done?**

1.28 To achieve the ambition contained in this Locality Plan there are a number of **Transformation Priorities** all of which will interlink to form the whole system transformation of health and care provision across the City, driving improvements in health outcomes for our residents:

- The Public's Health
- Living Longer, Living Better
- Primary Care
- Urgent and Emergency Care
- Cancer Care
- Mental Health
- Learning Disability
- Children and Young People
- Housing and Assistive Living Technology

- A Single Manchester Hospital Service
- 1.29 Detailed work is underway shaping and designing the new model of care. This includes extensive data analysis to identify the patients/residents who currently make the most demands on the existing health and care system and examining how the model of care will be designed to better accommodate their needs within an integrated community based model. Identifying the known cohorts of patients, care modelling and financial modelling is being undertaken to assess the potential impact by area of spend, defining the cost of the new arrangements, undertaking a cost benefit analysis comparing savings and investment, and establishing new payment mechanism for the services provided.
- 1.30 Alongside this, work is being undertaken to build for the longer term a culture change in residents enabling greater personal responsibility for health and wellbeing and to support people to be active partners in their care.

### **Proceeding towards implementation**

- 1.31 New governance arrangements have been put in place to drive implementation of Manchester's Locality Plan. These include ensuring that the Health and Well Being Board have strengthened executive and non-executive functions which provide strong strategic leadership and the means to ensure implementation and delivery of the ambition contained within the Plan. These arrangements are underpinned by a Joint Commissioning Board, a Manchester Provider Board, and a Locality Plan Programme Board.
- 1.32 This Plan goes on to outline actions to be taken to put the new care model in place.

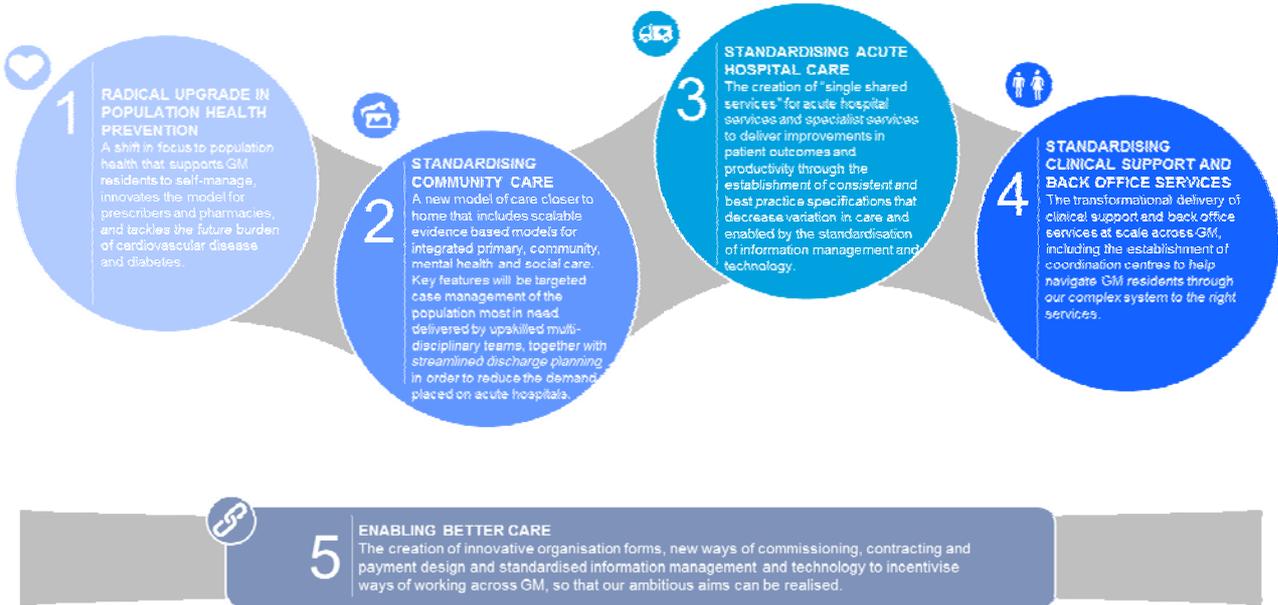
## 2. Context

### The Greater Manchester Plan – ‘Taking Charge of our Health and Social care in Greater Manchester’

2.1 ‘Taking Charge of our Health and Social Care in Greater Manchester’ was published in December 2015. It is the Greater Manchester Plan to achieve a clinically and financially sustainable health and social care system over the next 5 years. It is a plan to:

- Improve health;
- Improve quality and outcomes of health and social care;
- Ensure financially sustainable services;
- Reduce the health inequalities gap between GM and England and also across GM; and
- Unlock broader devolution opportunities to support broader public sector reform.

2.2 The GM Plan contains 5 main themes on which reform needs to focus in order to support transformation and ensure sustainability of our health and care system. Figure 1: GM Transformation themes illustrates



### Growth and Place

2.3 Over the last decade Manchester has been the fastest-growing City in the UK. The City Councils forecasting model predicts population growth in Manchester to rise to between 543,100 and 577,800 by 2021.

2.4 In contrast to the national picture, Manchester has a comparatively young population. Currently, nearly two-fifths (39%) of the population are aged under

25 compared with around 31% in England as a whole. In contrast, just 10% of the population is aged 65 and over compared with 17% in England. Data from the 2011 Census also shows that the population of Manchester has become more diverse in the last decade, with a reduction in the proportion of residents classifying themselves as coming from a 'White' ethnic group (from 81% in 2001 to 66.6% in 2011).

- 2.5 Although Manchester has recovered faster than most places from the economic downturn, it started from a low base following decades of decline in the previous century and continues to suffer from deprivation with a disproportionately large number of residents in low paid and part-time jobs. Manchester also has one of the highest rates of child poverty in the country with over 30% of children aged under 16 living in poverty. Although the trend is reversing, with a decrease in child poverty while the population of children is increasing, there remain significant numbers of families that are dependent on public services.
- 2.6 The NHS and social care providers have a key role to play as employers of Manchester residents and families. The scale and value of employment offered by the sector is wide ranging and expansive – ranging from highly skilled roles in research and academia to apprenticeships. Multi-disciplinary teams with more flexible roles will provide opportunities for frontline staff, for example in homecare and residential care, to develop new skills and to find new career ladders.
- 2.7 Health and social care services and the role of health sciences and academia are hugely important to economic growth in Manchester and indeed GM. The development of Medipark in Wythenshawe and City Labs on the Oxford Road corridor and the partnership between CMFT, UHSM and Manchester University will be a significant driver of growth and new jobs.
- 2.8 The UHSM, CMFT and North Manchester General Hospital (NMGH) sites are very significant features in the physical fabric of the City. Investment has taken place in CMFT, YHSM and Withington. This has been key to improving the structure of the buildings, as well as enhancing the ability to deliver different systems from the estate. Investment into the NMGH site is a key gap which needs to be addressed. The physical development of the City will need to accommodate new models of delivery, such as extra care housing and supported accommodation incorporating telehealth and telecare to transform productivity.

### **Partnership with Manchester People**

- 2.9 Manchester is becoming a world class City with an even more competitive economy. Manchester people will become increasingly highly skilled, aspirational, resilient, connected to growth and therefore increasingly productive. Encouraging and supporting Manchester residents to be resilient and active is central to this Plan. The strengths of our sporting legacy will enable the City to be a place where making the healthy choice is an easy choice. People will be able to look after their own health and be active. By

bringing together health providers, the City Council, community and voluntary sectors, the experience and outcomes of people will be transformed by putting them at the centre of the services.

- 2.10 Manchester is committed to maintaining its successful approach to ensuring equality for its citizens. The ongoing commitment to Communities of Interest including Lesbian, Gay, Bisexual and Transgender will remain as part of ensuring that the health and social care integration respects the needs and wishes of all parts of the Manchester Community. Manchester has one of the most ethnically diverse populations in the Country. Health and social care delivery will respect the variety in peoples care needs and cultural differences. The voluntary and community sector will be central to this commitment.
- 2.11 Keeping people safe is intrinsic to the principles of the Locality Plan. Living a life that is free from harm and abuse is a fundamental right of every person. Consequently, the emphasis is an integrated, partnership response for all the people who use our services, their families and carers. We will work in partnership to safeguard children, young people and adults, enhancing their health and wellbeing and protecting the rights of those in the most vulnerable situations.
- 2.12 Within Manchester there is an absolute commitment to ensure that common processes and thresholds are applied and that they are robust and consistently quality assured across the partnership.
- 2.13 Manchester has embraced the approach of preventative measures, recognising complex dependencies, offering early Intervention at the right time and Making Safeguarding Personal to our population. This will ensure that when children, young people, adults and their families face challenges and need help; they can easily access the support before the issue escalates. The focus and new approaches are embedded throughout the Locality Plan.
- 2.14 With an expanding and youthful population, Manchester has enormous potential to create clear routes for young people to develop the right skills to take up key employment and education as well as being able to lead safe, healthy and fulfilled lives.
- 2.15 The Age-friendly Manchester programme recognises the importance of supporting people to live healthy, active and independent lives as they move into older age. The city's voluntary and community sector and local networks are an important element of enabling older people to play a full part in the life of the city.

### **Public Service Reform**

- 2.16 The level and scale of public services will shrink over the next five years. The cost and extent of services currently provided will no longer be sustainable or deliverable. We can and will make services, particularly hospital services, more efficient. But, on its own this will be insufficient. It will also be necessary for the public to be more informed about their health and to take a greater

responsibility for their own health care. It will also be necessary to reduce or deflect demand on expensive hospital and residential care services by integrating services in the community. This is why health and social care services are at the heart of public service reform. Greater emphasis will be placed on prevention and ensuring that the right intervention is made as early as possible to minimise the call on public services.

2.17 Public service reform in Manchester is based on the following principles:

- Using evidence-based interventions to improve outcomes;
- Integration and coordination of public services;
- Whole-family/whole-person approach to changing behaviour;
- Developing new approaches to investing and aligning resources from a range of partners on joint priorities, and
- Robust evaluation of what works to reduce demand on public services.

2.18 The three reform priorities for Manchester are:

- complex dependency to employment, 'Confident and Achieving Manchester';
- health and social care integration;
- improving early years and school readiness.

2.19 The fundamental review of services to children announced in the summer 2015 budget creates the platform to transform health and social care services for children also. The purpose of this Plan is not only to show how the priority of health and social care integration will be delivered, it is also to connect that reform to the reforms to reduce complex dependency (including low skills and worklessness) and the reform of services to children and early years.

2.20 The financial challenge facing Manchester will only be met if we reform to meet rising demand in radically different ways. Efficiency programmes are necessary, but on their own will be insufficient. This plan therefore focuses on taking reform into the transformation of how services are delivered.

### **3. Building a Sustainable future for NHS and Social Care services**

- 3.1 First and foremost the family is the primary context in which health and care takes place. Strengthening all generations of the family, leading to active residents with responsibility for their own health needs is central to a sustainable future for the NHS. Our ambition is for the people of Manchester to keep themselves as happy and healthy as possible so that they get full benefit from the opportunities provided by the city's growth.
- 3.2 When health needs arise we aim to provide the highest quality care as efficiently as possible. Whilst most people do not regularly use services, those with long term, complex conditions do frequently need care, and ensuring that these people receive the right interventions, in the right order, at the right time is central to the integration health and social care.
- 3.3 Services will be integrated to enable people to become, and remain, healthy. This Locality Plan outlines the major programmes of change that will deliver the four types of sustainability: outcomes for Manchester People, high quality services, a balanced budget and movement towards self-care.
- 3.4 These programmes, incorporating children and adults, focus on public health, cancer, primary care, integrated community based care (Living longer living better), mental health, learning disability shared services across the acute sector, and housing and assistive living technology.
- 3.5 Each of the programmes is accompanied by a 'Logic Chain' which is set out in a table (or for some programmes a series of tables) and included as an appendix. The purpose of the logic chains is to set out the theory of change underpinning each of the Transformation Programmes, i.e. the underlying theory as to why we think that the activities we are undertaking will lead to certain outputs and thence to the intended outcomes and impacts for the people of Manchester. The logic chains are not a performance framework in themselves but they will help us to build a robust performance monitoring framework that tests the key assumptions and hypotheses that the Locality Plan is built on.

## Transformation 1: The Public's Health - Person, Partner, Place

- 3.6 **Person, partner, place** outlines the strategic approach to the *radical upgrade in prevention* across Manchester and more proactively promotes improvements to wellbeing, prevention of ill-health and reduction in health inequalities for the residents. This approach recognises that all Manchester's residents and the communities within which they live, have strengths and assets that can promote physical and mental health and wellbeing. These assets include the skills, knowledge, resources and support available within individuals, carers and the community.
- 3.7 The vision of the Manchester strategy is "...to unlock the power and potential that exists in all communities to improve the lives of people in the city and create thriving neighbourhoods where people can have a sense of purpose and belonging". Communities with strong social networks, high in social capital, can buffer the impact of stress and adversity on health (enhancing resilience) and have a positive impact on the health and life expectancy of their residents.
- 3.8 The Greater Manchester Strategic Plan aims to close the gap between GM and England for 7 key population health outcomes over 5 years. At least one third of the change required will need to be delivered by an improvement in the outcomes for Manchester (Appendix 3). This will require an ambitious program of local prevention activity that addresses the root causes of poor health.
- 3.9 Our approach to prevention (i) focuses on what matters to the **person**; (ii) is collaborative, where residents and communities are active **partners** in their health and wellbeing; and (iii) is **place** based, utilising local assets and resources for health and wellbeing. It will form part of a broader framework for asset based approaches being developed for the City. Community assets include skills and connections of local residents, local associations and groups, arts and cultural assets, resources of organisations, local stories, and physical resources such as buildings, parks and, libraries.
- 3.10 Neighbourhood health and social care teams, led by primary care and including community health services, dentistry, pharmacy and optometry will work together to improve the health and wellbeing of their populations. At the heart of this new approach, will be a connection between neighbourhood health and social care services and local community groups, organisations and residents. Together they will;
- Increase people's control over their health and lives, enabling self-care;
  - Connect people to community assets and resources that improve social connectedness and promote their physical and mental health and wellbeing;
  - Strengthen, build and mobilise assets within communities that promote physical and mental health and wellbeing;
  - Develop and deliver local health plans based on locally identified assets and priorities;
  - Increase equity in access and uptake of appropriate services for prevention and early identification of ill-health.

- 3.11 A new **primary care based prevention** programme will embody this approach. The concept of the “primary care workforce” will be transformed to facilitate prevention and proactive care, as part of One Team. New functions will be developed that enable neighbourhood health and social care teams to **connect with communities**, maintain **knowledge of community assets** and **develop local plans** that are locally driven and co-produced. These functions include community link workers and social prescribing, health and wellness coaching and volunteer time-banking.
- 3.12 Neighbourhood healthworkers will have and **community asset building** function, as part of the Wellbeing service. We will also engage the broader public sector workforce in using brief conversations that promote health. This will form part of Manchester’s broader strategy for an asset based approach – “Our Manchester”.
- 3.13 A number of requirements will underpin the new way in which neighbourhood health and social care teams work with communities, these include;
- Person before place – recognising that non-place based communities exist of people who share a common identity or affinity;
  - An asset based mindset – shifting the focus from needs and deficits to strengths and assets;
  - Investment in the time required to support a cultural shift for health and social care commissioners and providers to new ways of working;
  - The support of community learning in relation to health and social care;
  - Development of relationships that enable understanding and engagement of communities;
  - Use of champions and early adopters to promote new ways of working
  - Collaborative and cross-sectoral working;
  - Development of monitoring and evaluation measures that measure impact on individuals and organisational change.
- 3.14 “**Prevention**” is often used to refer to reducing the lifestyle behaviours (e.g. smoking, alcohol, obesity) that lead to ill-health. However the greatest long-term return on investment will be seen from interventions that modify the social determinants of ill-health and health inequalities. The new community based, ways of working will allow health and social care teams to support residents in tackling the social determinants of health such as employment, finance and housing, and support the adoption of healthy lifestyle choices. Physical activity and exercise, participation in arts and cultural activity and connecting with social groups can all play a part in healthy lifestyles and promoting wellbeing.
- 3.15 **Giving every child the best start** is crucial to reducing health inequalities across the lifecourse. An integrated children’s public health service will be developed including health visiting, family nurse partnership, and school health services alongside other children’s services. The plans for children and young people’s health and described further in transformation priority 8.
- 3.16 **Work and health** - people in work live longer healthier lives and this also has benefits for the local economy. Supporting people into employment is

therefore a critical part of our approach to prevention. We will scale up provision of two established programmes; “Healthy Manchester” supporting patients citywide who are out of work move towards employment, and “Fit for Work (in work)” supporting patients who are in work, but off sick and at risk of losing employment. We will also improve commissioning and integration between health and employment services, and promote the health of the people we employ.

- 3.17 **Age Friendly Manchester** a key component of the lifecourse approach with the aim of enabling people to keep well and live independently as they grow older. At the heart of this approach is the promotion of age-friendly neighbourhoods – working in localities to enable social networks and activities which improve social connectedness. From 2016 the Ambition for Ageing programme will be using this approach to tackle social isolation in local areas.
- 3.18 **Healthy lifestyles** - our primary care prevention programme will provide a holistic approach to supporting people to lead healthy lifestyles. However for some people, more intensive support is required. Services will be available for those who need more specialist support for smoking cessation and weight management. An integrated alcohol and drug early intervention and treatment service for adults will roll out in April 2016. Sexual health and reproductive health services are being developed to allow residents to receive sexual health and contraception services from the same provider.
- 3.19 **Arts and culture** - There is increasing recognition of the role that arts and culture can play in prevention and supporting health and wellbeing. Proposals will be developed to strengthen this role within our prevention programme and the use of the arts to support recovery.
- 3.20 Year 1 delivery for transformation will focus on the recommissioning and launch of key public health services and the development of a primary care based prevention programme. The programmes delivering in 16/17 are detailed below:

1

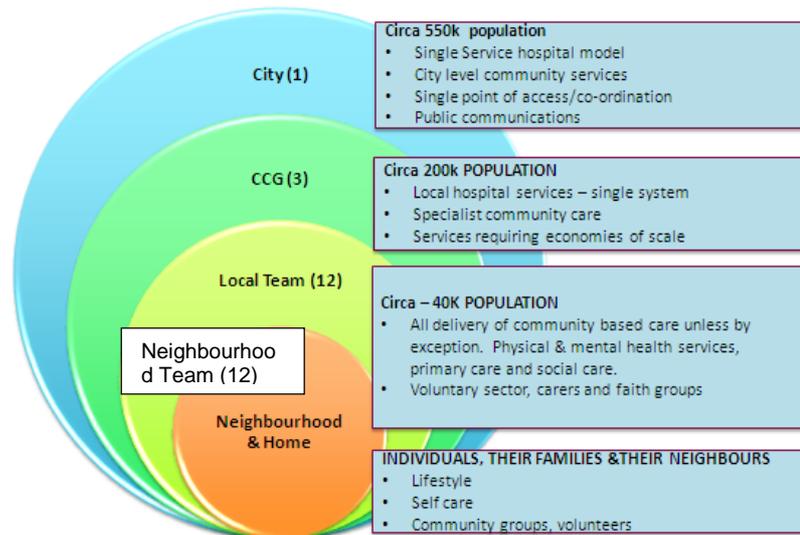
Radical  
upgrade  
in population  
health  
prevention

- Wellbeing service transformation - Preventative services have a key role in reducing ill health, worklessness and dependency in the city – the new service will be based on a community asset building model with a small element of one to one support for those who are unable to access community provision.
- Development of an Integrated Children’s Public Health Service, including health visiting, family nurse partnership and school health services alongside other children’s services.
- Roll out of Integrated alcohol and drug early intervention and treatment service for adults from April 2016.
- Development of an Integrated sexual and reproductive health service.
- Primary Care Based Prevention focused on:
  - Finding the missing thousands’ - Identifying people at risk of developing long term conditions and detecting conditions in people who have not been diagnosed.
  - Proactive management and optimisation of patients – Working with local services to ensure that once identified, patients receive optimum care to manage their condition(s).
  - ‘Social Prescribing plus’ – We will be seeking to give all GPs in Manchester access to a wellbeing coach/advisor who also acts as a community navigator and to whom they can refer patients who meet the criteria "on prescription".
  - Enabling Self-care - This programme of work will provide the training and support required to facilitate primary care staff to enable patients to take an active role in looking after their health.

## Transformation 2: Living Longer Living Better

- 3.21 Living Longer Living Better is Manchester's programme for ***transforming community based care and support***. It embraces major change on an ambitious scale which has in scope all health and care services that are, and could be delivered in the community. This includes in the first instance, local district general hospital services, community health services, social care services, GP primary care and wider primary care services, community mental health services ambulance services.
- 3.22 Transformed primary care services will be at the heart of this Programme, leading integrated out of hospital services as a whole sector of care, greater than the sum of its individual constituent parts or practices. The vision is that primary medical services will integrate in neighbourhoods with community pharmacists, allied health professionals, community nurses, social care staff, intermediate care services, ambulance teams and the voluntary and community sector to secure multi-skilled care for patients close to home on a neighbourhood footprint. GPs will have a leading role within the teams to ensure co-ordination between services and professionals, enabling key workers to shape services around the bespoke needs of individual patients and their families and carers.
- 3.23 This programme will have as key drivers a focus upon identifying needs early through better early diagnosis of diseases, such as cancer; reducing demand on acute services through ensuring needs are met wherever possible within the local community from the assets available there; reductions in time spent in hospital/length of stay; reductions in delays in discharging planning and transfer of care; and importantly reductions in the variability and delivery of care provided to patients.
- 3.24 As the teams develop they will incorporate some acute specialists such as consultant geriatricians, psychiatrists and others to provide integrated specialist services in the community.
- 3.25 The delivery of LLLB will be through 'One Team – Place Based Care Model'. All services will be based upon a 12/3/1 model of provision. Most services should be delivered at the place based neighbourhood level (12) unless they require economies of scale at a specialist local level (3), or a single Citywide level (1).

## One Team – Place Based Care



- 3.26 The key transformation will be the establishment of 12 Neighbourhood Teams across the City. These teams will be based on geographical area as opposed to organisation, and formed through existing services, populated with existing practitioners. The teams will focus on the place and people that they serve, centred around the ethos that 'The best bed is your own bed' where ever possible and care should be closer to home rather than delivered within a hospital or care home.
- 3.27 Working in this way, One Team will enable shift the focus from:-
- Organisation to place
  - Disease to person
  - Service to system
  - Reactive to proactive care
  - An unaffordable system to progressive upstream investment
- 3.28 Commissioners in Manchester have worked collectively to build the One Team Specification. In response, the 11 NHS and social care statutory providers (including all GP organisations in the City, all acute and integrated community trusts in the City, the Mental Health Trust, the Council and the ambulance service) have come together as a Manchester Provider Group to provide a collective provider response to the One Team Placed Based Care Model.
- 3.29 A wide range of services will be delivered in the future in a place based model in either 12 hubs, three localities or across the City. These include intermediate care and reablement, care management, urgent care first response, DGH functions, Community mental health, primary care, residential, nursing and home care.
- 3.30 The LLLB programme operates at the community level with 'One team, Place Based Care' which has mental health services fully integrated in the future arrangements for the provision of community services. It is a key programme

for delivering change to mental health provision and encouraging a more integrated approach to service delivery. Currently there is a multiplicity of providers and this fragmentation in the mental health system impacts negatively for people. Therefore, commissioners and providers wish to be bold in order to change the reactive way of working and to focus on prevention and early intervention

- 3.31 A fundamental element of the One Team approach is the integration of social care within the 12 neighbourhood teams. This will integrate social care with:
- Wraparound service offers for mitigating and responding to crises;
  - 7 day working to support current models such as reablement;
  - A joint approach to assessments and care planning;
  - A fresh approach to support;
  - Stronger links between adult services and wider City services providing an integrated whole family offer Manchester people;
  - More innovative use of ICT to share data between providers and to facilitate new ways of working such as a telemedicine and shared records;
  - Better integration of physical and mental services assisting a wide range of patients including those with dementia.
- 3.32 The LLLB programme will work with public health, linking with the Early Years strategies and other relevant programmes (such as complex dependency) to align and integrate where appropriate. This will include a focus on the three populations identified within LLLB that focus on children:
- Children with long term conditions;
  - Children at the end of life and palliative care;
  - Early Years implementation.
- 3.33 Urgent Care First response (UCFR) is a citywide approach, in response to the One Team specification, designed to reform the whole urgent care system in Manchester. It will bring together the different components of urgent care into a single unified system, which will operate with three core components (1) First Contact - people with a need for urgent care will be directed to the most appropriate part of the urgent care system, (2) providing urgent care to patients with complex needs through the 12 neighbourhood teams, and (3) developing Urgent Day Care hospital/ambulatory care facilities.
- 3.34 The integration of homecare and residential care will be delivered by commissioning these services on the basis of providers who share the values and priorities of this Plan. We will seek partnerships with providers who can not only provide value for money, but also staff and services able to be part of the integrated teams of the LLLB One Team approach. This will also provide an opportunity to create new skill mixes and new career ladders for front line staff linked to the move towards a Living Wage.

### Dementia Care through LLLB

- 3.35 The new model of care, delivering integrated care through a community based model will provide the platform for better supporting those residents/patients suffering from dementia. The priorities here are to ensure:
- More people with dementia helped to remain living well at home;
  - That unnecessary delay and poor treatment will be avoided and stress reduced for the people living with dementia and their carers;
  - Preventable admission to hospital will be reduced and safe, sustainable and quick discharge to care and home increased;
  - To build an evidence base for dementia care, by bringing together data on the financial benefits to the acute sector of better and more integrated services for people with dementia in the community;
  - Optimise opportunities for new and innovative relationships with the digital, media and assistive technology industries.
- 3.36 There is a Greater Manchester work programme focusing on Dementia Health and Social care. This sets out clearly the vision for dementia care by 2021 across GM as *'the go to place for the best in dementia care, treatment and support'*, and recognises that the dementia challenge in GM is one of standardisation, care pathway re-design and implementation. We will work with the GM Team in the achievement of this vision.

### Transformation of District General Hospital Services

- 3.37 The implementation of LLLB, and the wider system changes across Greater Manchester through devolution, will drive the significant shift in emphasis and activity out of acute hospitals and into the community. In Manchester, we want a system which keeps patients well in the community, ideally at home, and only admits them to hospital when absolutely essential to receive care which can only be delivered in an acute hospital. To this end, through LLLB, District General Hospital services will be transformed for our population.
- 3.38 With the exception of some independent sector hospitals, integrated hospital and community care for adults in Manchester is mainly provided by three NHS trusts, operating from four main sites:

Trust	Site
Pennine Acute Hospitals NHS Trust	North Manchester General Hospital
Central Manchester University Hospitals NHS Foundation Trust	Oxford Road Campus
University Hospital of South Manchester NHS Foundation Trust	Wythenshawe Hospital Withington Community Hospital

- 3.39 Many district general hospital services, particularly those related to urgent care and management of long term conditions will be part of LLLB and integrated into One Team, facilitating seamless transfer of care between hospital, community, primary and social care.

- 3.40 Radically different models of care will focus on providing safe and effective care without admission to hospital; e.g. emphasis on ambulatory care, outpatient and day case treatments, and “one-stop shop”. Services will be provided 7 days a week.
- 3.41 DGH services for children will be provided through a linked up system in which the secondary care offer to the Manchester population Royal Manchester Children’s Hospital and Wythenshawe Hospital’s paediatric service is clearly defined. It will be supported by a network of children’s community nurses and primary care providers, skilled in paediatric care.
- 3.42 Key enablers of this approach will be:
- Workforce: able to move between settings and organisations, recognising the wider contribution of volunteers, carers and the third sector.
  - Improved estate utilisation: community teams operating from a single location in each locality.
  - Interoperable IT systems: enabling DGH services to share electronic information with primary care, community and social services securely.
- 3.43 In 16/17, the key work programmes delivering the implementation of One Team centre around:

**1** Radical upgrade in population health prevention

- All community based health & social care staff (700+) trained in enabling self-care (ongoing throughout 2016).
- 12 neighbourhood business plans developed that describe the preventative work that needs to be undertaken to improve health and wellbeing within specific neighbourhoods.
- Citizens Advice Joint Venture - advice and social prescribing service.

**2** Transforming community based care & support

- The establishment of 12 multidisciplinary neighbourhood health & care teams.
- The development of a new outcomes based performance framework for community health & care in operation.
- Securing investment in 16/17 and 17/18 for One Team models of care across the city.
- Better working with housing providers to support social prescribing, self-care, and extra care housing.

### **Transformation 3: Primary Care – *Consistent high quality care for the whole population***

- 3.44 Primary care services are **the** lead component in the programme for ***transforming community based care and support*** described in the previous section. Over the next five years leading up to 2020 and beyond, Primary Care services across Manchester will be transformed and will activity shape the integrated model of care (One Team) described above.
- 3.45 The vision for Primary care is that it will “deliver consistent high quality care for the whole population”. In order to deliver that vision, there needs to be an expansion and strengthening of primary care, and this will take place as part of the development of One Team.
- 3.46 Primary care services are delivered through a range of providers; specifically Primary Medical care through General Practice, alongside Pharmacy, Optometry and Dentistry services. The services are largely delivered through independent contractors through national contracts commissioned by NHS England. This will change for primary medical care in April 2016, as the three Manchester CCGs have been approved delegated responsibility for commissioning of General Practice from NHS England.
- 3.47 The vision is inclusive of all primary care contractor groups, although there is acknowledgement that these groups are moving at varying pace due to different models of provision and their current contractual arrangements. It is important to consider the links to GM Devolution, including their role in primary care transformation, and the GM Primary Care Strategy.
- 3.48 The provider landscape of primary care is changing. Primary care services are increasingly looking to be delivered at scale, rather than solely through the traditional independent contractor model. For example, for Primary Medical care, each one of Manchester’s 92 GP Practices is a member of a Federation, of which there are three in Manchester, one each in North, Central and South; and the 3 Federations come together to form the Manchester Primary Care Partnership, which provides the City’s extended access Provider Federations have also been formed across Greater Manchester to bring together Pharmacy and Optometry services.
- 3.49 The key components of the vision in relation to the offer for the population include the following:

**Access** – This has been consistently identified as the highest priority for patients and the public. Primary care is now available across Manchester 7 days per week, and through additional hours, as a result of the service provided by the Manchester Primary Care Partnership. In addition, the Manchester Standards for Primary care set out standards of access which state that patients should be able to access their GP practice in core hours; and be seen on the same day if needed. Longer term there will be a single point of entry with appropriate services available 24/7, to offer a viable alternative to A&E outside of core hours. In addition, Community pharmacy will

be available to triage and treat minor ailments and injuries, as well as any medication queries, on a more local level.

**Proactive management of people with long term conditions** - In Manchester, care for patients with one or more long term conditions will be provided at an early stage, to reduce disease progression, which will be complemented with both holistic and specific health education. Vulnerable and at risk patients will be identified and managed using risk stratification and predictive modelling, which will consider the whole person rather than just the condition, resulting in coherent and effective intervention. Community pharmacy will work collaboratively with General Practice, to assist in supporting patients to manage their condition(s) in the community. These actions will result in reduced hospital admissions and improved health outcomes for people with long term conditions. Primary care will work alongside Public Health colleagues and other key partners, especially organisations within the Voluntary and Community Sector (VCS), to identify those patients who are at risk of developing long term conditions, or who may have developed a condition which has not been diagnosed, to ensure early intervention. Primary care providers will work in an integrated way with local services in the integrated neighbourhood teams to deliver optimum, proactive care to all patients, regardless of GP registration, resulting in improved health and wellbeing outcomes related to reducing health inequalities, unplanned admissions and mortality.

**Specialist services in primary care** - The range and scope of services provided in primary care and delivered in the community will be increased. The establishment of Federations by General Practice, Community Pharmacy and Optometry, coupled with increased collective working across primary care with other services within neighbourhoods, provides opportunities to better meet the changing needs of patients within the community. As more services previously delivered by the District General Hospitals are delivered in designated neighbourhood locations in the community advanced diagnostics allow the provision of urgent care services closer to home. Specialist services will be developed, where appropriate, to meet the needs of the communities they are serving. One example of this is primary care colleagues working closely with care and nursing home teams, to ensure residents are receiving proactive, appropriate care in a setting they are comfortable with, which results in reduced hospital admissions and improved outcomes for patients.

**Empowerment of patients** – Patients will be at the heart of their care, with involvement in every stage and every decision. Where the patient deems appropriate, this will be extended to their family, friends and carers to support them at their time of need. Primary care will actively promote self care for patients, and will ensure that they are provided with tools to ensure this is effective. Health services will link more closely to communities through the introduction of “Social Prescribing Plus”, which includes a coaching element for patients to access local community support and to assist with sustaining healthy lifestyle choices. This coaching will further encourage and empower patients across Manchester to self care. Patients will have access to their care records, and be encouraged to input into their care. Patients who are nearing

the end of their life will be empowered to make a decision about where is the right place for them to die, and will be supported in this decision.

### Quality and standards

- 3.50 The Manchester CCGs have agreed a set of standards for primary care, known as 'Enhanced Standards for Manchester people'. These standards are consistent with the Greater Manchester standards, and are statements of best practice in the areas highlighted. The aim of the standards is to improve health outcomes for patients, optimise resource utilisation and reduce health inequalities. The vision for Manchester is that all 92 practices are signed up to deliver the standards on either an individual, locality or Federation footprint. The standards are also intended to apply to other primary care services, such as community pharmacy.
- 3.51 Overall, the main focus of the standards is to improve quality of care and outcomes for a range of conditions, ensuring the patient has a positive experience of primary care within a safe environment. The standards cover various priority areas including improving access to general practice within core hours, as well as improving outcomes for people with long term conditions, which underpin components of the vision. They also include improving health outcomes for patients with mental illness and learning disabilities, which will ensure parity of esteem is achieved within Manchester and importantly, improving the health and wellbeing of carers. All of the standards are underpinned by engagement of GP practices in a review process to help with understanding where improvements could be made.

The standards will form a key part of the transformed model of primary care, to ensure that patients are receiving consistent, high quality care on the citywide footprint of Manchester.

In 2016/17 the key work programmes transforming and developing primary care will be:

1

Radical  
upgrade  
in population  
health  
prevention

- Development and implementation of Primary Care based prevention programme.
- Implementation of city wide primary care standards, focused on Long term conditions.

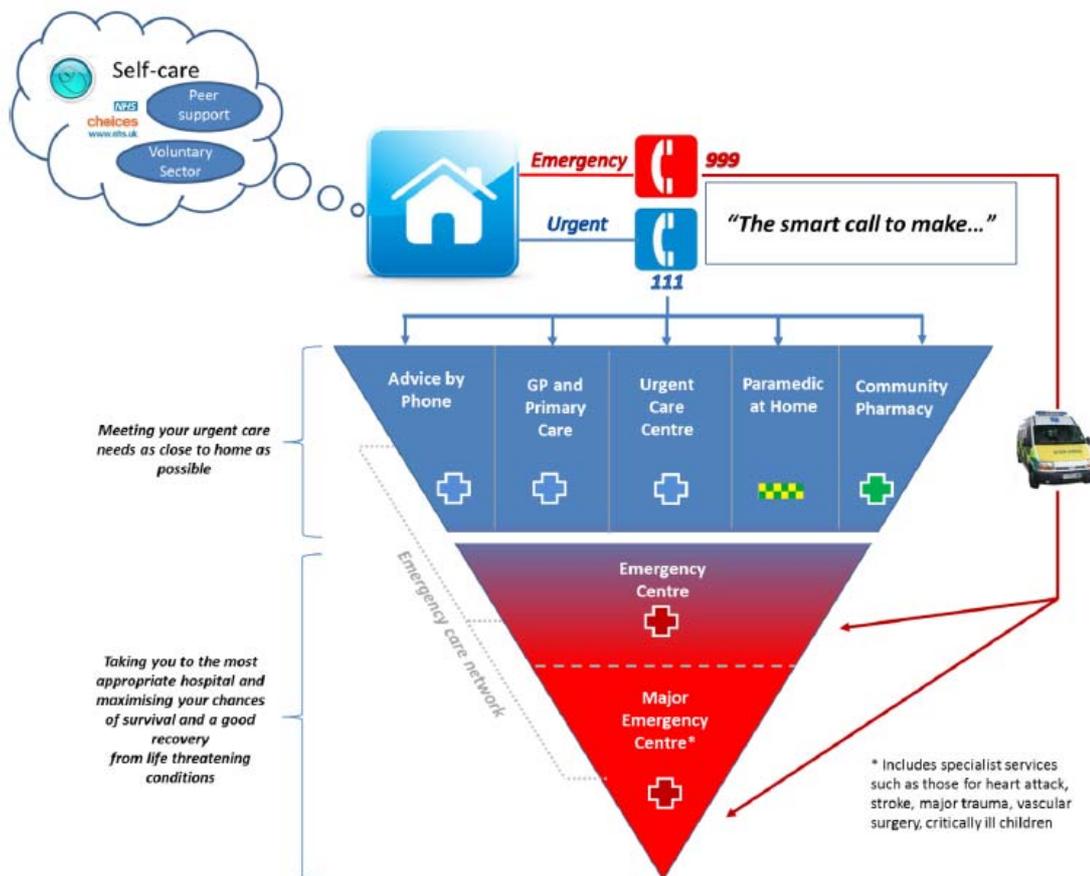


2 Transforming  
community  
based  
care &  
support

- Development of the Integrated model of primary care to support One Team.
- Implementation of citywide primary care standards:
  - Standard 1 - In Hours Access
  - Standard 6 - Improve outcomes for people with long term condition(s)
  - Standard 9 - Member Engagement and Peer Review.
- The development and Implementation of a Citywide Strategic Estates Plan, in line with estate requirements for the One Team approach across the city.
- Full delegated decision making of all GP contracts.
- Implementation of the workforce strategy and workforce plan.

## Transformation 4: Urgent and Emergency Care

3.52 The vision for urgent and emergency care in Manchester is in line with the national vision of the provision of a highly responsive service that delivers care as close to home as possible with minimum inconvenience and the very best expertise and facilities. This spans self-care, accessing the right advice or service first time, improving services outside hospital and ensuring emergency needs are treated in specialist centres. The whole urgent and emergency care system will only operate as effectively and efficiently as possible by introducing a system approach. The figure below from NHS England describes the proposed look and design of the new system.



3.53 Faced with increasing pressure on urgent care services through increases in demand brought about by factors including an ageing, sicker population, the national strategy for urgent care was set by the 2014 Urgent and emergency Care Review led by Sir Bruce Keogh and provides a programme of transformation.

3.54 Elements of the offer are described below:

- Effective management of **interfaces and handovers** by the sharing of key patient information to ensure continuity of care and agreeing processes.
- Improved **system management** by having oversight of the whole pathway by the development of a Manchester Urgent Care Network Board which will have strong links to the System Resilience Groups.

- Supporting people to manage **long-term conditions** by creating programmes to help people develop their knowledge, skills and confidence and offering integrated, multi-agency approaches.
  - Managing **seasonal pressures** by ensuring sufficient capacity to manage variation in admission numbers, increased efficiency and effort for above average admissions, multiagency collaboration for longer stay cohorts with complex discharge needs, maintaining a functioning system over holiday periods to prevent loss of discharge capacity, balancing elective and emergency care and having robust escalation plans.
  - Improving the care of patients in **residential and nursing homes** by co-ordinating input from generalists and specialists in partnership with social care professionals and care home staff who have shared goals, reliable communication and trust.
  - Increased role of the **community pharmacy** to reduce pressure on General Practice and enhance patient safety.
  - Ensuring consistent good practice in **A&E departments and acute medical units** to improve safety and flow and to help reduce unwarranted variation and manage demand. Prevent crowding in the emergency departments, get patients into the right ward first time and assessment by a senior decision maker as soon as possible and daily senior review (whether this is in primary or secondary care).
  - Improving **urgent mental health services** and access to general services by patients with mental health problems by resourcing 24/7 liaison mental health services.
  - Improved pathways for **frail older people** by assertive management using ambulatory emergency care and acute assessment units.
  - Getting patients to **specialist hospital** care to improve outcomes.
- 3.55 Managing urgent care in Manchester is highly complex; the three acute hospitals have led to the development of three System Resilience Groups (SRGs) in the city but no citywide resilience focus. Strategies to deliver improvements in urgent care, principally designed to deliver reductions in costly acute services such as non-elective admission and long term admission to social care, are increasingly being undertaken at a citywide level, particularly through the Urgent Care First Response programme.
- 3.56 The ambition for the Urgent and Emergency Care transformation programme is to cover the full range of redesign required to deliver the Urgent and Emergency Care Review, which goes beyond Urgent Care First Response and is consistent with both the One Team and Primary Care Transformation plans. The strategy will be developed using a collaborative approach with health and social care with involvement from voluntary and community groups, patients and carers. The strategy will be shared and understood by all partners and requiring commissioners and providers to work together to deliver change.

In 16/17, the key work programmes transforming urgent care will be:

2

Transforming  
community  
based  
care &  
support

- First Contact - Development of an integrated single point of access for urgent health and social care needs for Manchester: this will be undertaken in two phases; (1) to develop a tactical solution for an integrated access point for referrals from One Team professionals, (2) to develop and implement the 'First contact' model.
- Urgent Primary Care – Rationalisation and improvement of the urgent primary care offer for Manchester, including consideration of the use of walk in centres, extended and out of hours services, and the development of an integrated front end for each of the city's A&E departments incorporating current services such as A&E, pharmacy, social care, dental.
- Implementation of complex community response across the city.
- The establishment of Standardised Ambulatory Emergency Care Units in across the city to diagnose and treat patients on the same day and sent home with on-going clinical follow up.

5

Enabling  
Better Care

- Developing the appropriate financial and contracting models for the UCRF model.

## Transformation 5: Cancer Care across Manchester

- 3.57 Manchester has some of the worst cancer outcome indicators when compared to rest of the UK. Unhealthy lifestyles, low screening uptake and late stage at diagnosis contribute to high premature mortality rates. Also with improved survival, more people are living with and beyond their cancer diagnosis, living with consequences of their cancer and side effects of treatment requiring surveillance and monitoring, and therefore the support required for this. To address these challenges, an increased emphasis on prevention and early detection of cancer, alongside the development of new models of aftercare and palliative/end of life care is required.
- 3.58 The Macmillan Cancer Improvement Partnership (MCIP) is the key transformational programme across Manchester to improve cancer outcomes £3.45m has been committed from Macmillan Cancer Support for investment in two phases (1), targeted improvements in primary, community and palliative care across all tumour groups, and (2) focused improvements in breast and lung cancer pathways.
- 3.59 Building on the new National Cancer Strategy and the local Manchester CCGs Cancer Commissioning Strategy has identified several priorities for delivery:
- Patient Experience: Improving the use of high quality information for patients and carers to ensure that patients can report good experience of their care.
  - Prevention: Working with public health in the commissioning of primary prevention programmes e.g. for cancer and other long term conditions (smoking cessation, healthy eating, physical activity, alcohol consumption, exposure to UV radiation) to support the reduction in premature mortality, by reducing the number of people diagnosed with cancer.
  - Early Detection: Commissioning of cancer services in Manchester will focus on prevention and early detection in order to reduce incidence, detect cancer at an earlier stage through symptom recognition and take up of the national cancer screening programmes.
  - Diagnostics: Meeting the new standard of diagnosis within 4 weeks of GP referral for suspected cancer
  - Treatment: Co-ordinated timed pathways to meet Cancer Waiting Times Standards.
  - Survivorship: The provision of high quality cost effective supportive services for patients to improve wellbeing, reduce the risk of recurrence or manage consequences of treatment or disease progression.
  - End of Life Care: Better co-ordination of care for people at end of life.

Transformational programmes for cancer delivery in 16/17 will be:

**2** Transforming  
community  
based  
care &  
support

- Delivery of Manchester's Acceleration, Coordination and Evaluation (ACE) Wave 1 schemes: piloting of low-dose CT scanning for those at high risk of lung cancer; and working with GP practices to improve bowel screening uptake.
- Exploration of new models of diagnostics to support early detection; A Greater Manchester bid has been made to ACE Wave 2 for the development of a vague symptom pathway and piloting of multi-disciplinary diagnostic centres in Oldham and Wythenshawe Hospital.
- The implementation of Electronic Palliative Care Co-ordination System – Ensuring that appropriate patients are recorded on EPaCCS shared care record. This will support the active engagement of the Greater Manchester CCGs and Providers in the Greater Manchester Cancer Vanguard, which aims to establish a single system provider for Greater Manchester Cancer Services.
- Reducing diagnoses through emergency admissions, through GP engagement and education programmes.
- Active engagement of the Greater Manchester CCGs and Providers in the Greater Manchester Cancer Vanguard, which aims to establish a single system provider for Greater Manchester Cancer Services.

## Transformation 6: Mental Health

- 3.60 The mental health of citizens in Manchester is integral to its success as the effects of poor mental health and wellbeing are to the detriment of individuals, the social cohesion of their communities and the economic growth of the city.
- 3.61 Mental health is a significant issue for Manchester – for residents affected by, and living with, mental health problems as well as organisations delivering services. Manchester has a clear vision of improving services and by 2020 aims to have acute and serious episodes of mental illness treated more safely and providing a substantially improved service for Manchester residents. The ambition is to deliver a safer and more effective management of acute and serious episodes of mental illness. As the link between mental illness and unemployment is established, the intention is to increase the number of people who can regain skills after serious mental illness.
- 3.62 A key driver for improvement is to help people maintain the best quality of life when they have severe and persistent depression.
- 3.63 The overarching approach to good mental health and wellbeing must take account of the needs of people, at their different stages of life and ensure that the services and support available to them is:
- Preventative, ideally avoiding the need for intervention from specialist practitioners by effective public health programmes in communities and workplaces.
  - Accessible at the times needed to prevent worsening of symptoms and especially to intervene early in crises.
  - Integrated into the needs arising from and affecting physical health.
  - Responsive to need and ‘recovery’ focussed ensuring people are supported and encouraged to return to active working lives, where relevant.
  - Clear in its pathways of care for all users of services through children’s transition to adult services and pathways to more intensive and restrictive settings where necessary.
- 3.64 The ‘system’ then, needs to ensure that it is effective, efficient, based on ‘best practice’ and outcome focussed so that services are sustainable and provided as close to the users community as possible. These principles drive the ambition of the city in its development of mental health services which require close collaboration between all stakeholders including health and social care providers, the third sector, Police services, housing and the Department of Work and Pensions (DWP). The role of carers cannot be underestimated and their full engagement in all our plans is crucial to their success.
- 3.65 The costs to the health care system of our current approaches are significant – poor mental health makes physical illness worse and raises total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. This suggests that between 12 per cent and 18 per cent of all NHS or GM expenditure, between £420m and £1.08bn. The

more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.

- 3.66 Current mental health services in Manchester do not provide the best value for money nor generate the best outcomes for patients with long waiting lists and high use of “out of area” beds. By outlining care pathways, the current fragmentation between services will be reduced with improved access to integrated delivery.
- 3.67 The “One Team” approach proposes that mental health services will be fully integrated in the future arrangements for the provision of community services. It will be key for delivering integrated mental health provision, as described in Transformation 4.

### **Neighbourhood, Locality and City**

- 3.68 Many people with physical health conditions also have mental health problems. Currently physical and mental health treatments tend to be delivered, as separate health services. Care for large numbers of people with long-term conditions will be improved by integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. This will also allow us to provide MH training and awareness to all neighbourhood teams and community services to ensure the chance of stigma is reduced.

### **Supporting Complex Dependency and Worklessness**

- 3.69 We are supporting people with a range of complex needs by working collaboratively across local services to deliver the right support at the right time. The provision of mental health support as part of packages of support through the expansion of Working Well, the Troubled Families Programme and complex dependency will strengthen our ability to ensure all residents are able to benefit from the conurbation’s economic potential.
- 3.70 The links between employment, wellbeing and mental health are well established therefore, access to therapeutic interventions at the right time are critical to keep people in or return to work. The urgent care response for young people in crisis is an area for further development and improvement in Manchester. This applies too for those with learning disability where there are associated mental health problems.

### **Children and Young People’s Mental Health**

- 3.71 The numbers of children in the UK affected by mental illness has risen particularly fast in the past 10 years. An estimated one in 10 children and young people suffer from a diagnosable mental health disorder. These problems are a significant personal, social and economic burden not only on the children and young people themselves, but also their families, carers and the community.

- 3.72 The early detection of mental health problems through all stages of a child's life is crucial. The antenatal period and early years represent vital development stages when problems with child development, speech and behaviour can arise. We will ensure that there is:
- Intervention to make a difference both for individuals and populations at this time will help to avoid social and health problems in later years.
  - Access to appropriate support in teenage years is a priority, with access to appropriately resourced and trained staff in education settings and wherever young people may seek help.
  - Development of pathways of care through a common point of access for all agencies supporting children and young people in Manchester will help all children access the right support in the quickest way possible.
- 3.73 The emphasis will be on the prevention and emergence or escalation of mental ill health by:
- Active health promotion/support and early intervention within the community.
  - Access to the right age appropriate support in the right place at the right time by an appropriately skilled and informed workforce delivering evidence-based interventions.
  - Ensure the early detection and on-going treatment of physical health problems, through GP screening; in addition to the mental health support available to all our children and young people.
- 3.74 For those young people already in receipt of CAMHS services and approaching adulthood we must ensure a timely appropriate and planned transition to adult mental health services through integrated pathways. Bringing the parts of peoples care together without them noticing the join.

### **The Greater Manchester opportunities**

- 3.75 There are great benefit to be achieved by looking beyond the city boundaries for future change and improvement to mental health services. These relate largely to:
- The ability to collaborate between organisations and agencies, providing for example GM wide AMHP services and crisis response.
  - The integration of services which are highly specialised and require greater critical mass than available in separate economies. This could apply to:
    - CAMHS
    - Learning disability services
    - Psychosexual services
    - Autistic Spectrum Disorder (ASD) services
    - Crisis Response
  - It is recognised that there is also opportunity to re-consider the 'footprints of delivery' for NHS Trusts across greater Manchester which could result in a reduced number of organisations and a greater economy of scale for

corporate and support services, allowing a higher proportion of spend to be directed to direct patient care.

- Provision System that can combine critical mass, expertise and development opportunity with the ability to be flexible in local delivery to address the differing needs of local populations in relation to health and social care integration. This may lead to the restructuring of the current “footprints of delivery” of the 4 existing Trusts and/or organisational change that reduces the number of organisations. To ensure these are provided on a cost effective and sustainable basis. At a GM Level we will ensure that the devolvement of NHS England budgets relating to Specialist Mental Health Services be used to break the current paralysis of strategic planning and opportunities. We will also tap into our academic assets through the MAHSC and AHSN to support the spread of evidence based practice.

3.76 At a GM Level we will also ensure that the devolvement of NHS England budgets relating to Specialist Mental Health Services be used to break the current paralysis of strategic planning and opportunities. We will also tap into our academic assets through the MAHSC and AHSN to support the spread of evidence based practice. The Greater Manchester Devolution will play an essential role in transforming acute and hospital care. By realigning investment to early intervention and proactive care, there will be a positive impact on the quality of life of people with mental health issues. The number of people entering and completing IAPT should increase, with a higher recovery rate. By 2020 there should be a reduction in mortality rate from suicide and undetermined injury and more people living in appropriate accommodation.

In 16/17 the focus of the Mental Health Transformation across the city will be:

**2** Transforming community based care & support

- Completion of the MMHSCT transaction and procurement of a Citywide Mental Health, Social Care and Wellbeing Service.
- Development of improved rehabilitation from the Severe and enduring mental illness pathway, which aims to reduce the need for out of area hospital rehabilitation placements, offer the right support closer to peoples’ homes; and increased value for money.
- Active shaping of community mental health services within the One Team model.
- Implementation of MHIP including:
  - Reduction of out of area placements for mental health acute care,
  - Improvement of the mental health liaison offer within acute hospitals:
  - Improvement of the Common Mental Health Problems pathways ensuring delivery against national ‘Must Do’ access targets (IAPT national indicators; 18 week, access and recovery)
  - Improvement of First episode psychosis pathways ensuring delivery against national Must Do access targets.
- Mental Health Grants Scheme aimed at improving the health and wellbeing of people with serious and enduring mental health problems, access to IAPT provision and the support offer for people with mental health problems by basing services within One Team areas.

## **Transformation 7: Learning Disability**

3.77 A transformation of services for LD people is required to reduce reliance on inpatient and hospital care by reducing the factors that lead to emergency and crisis admissions and prevent unnecessary admissions. This will require the development of a new delivery model for specialist care, universal service and community support and a new approach to what should be developed at GM level and what should be delivered locally. This will be across GM, citywide and at a local level. The priority is to support people to live independently in the community with appropriate step up and step down wrap around health and social care services and investment will be required to develop a new residential estate.

3.78 The ambition contained in this plan is to:

- a) Through commissioning mechanisms agree a local plan to close the gaps in outcomes for people with learning disabilities.
- b) Work across the commissioning and provider partnerships in stimulating the supported living sector to provide appropriate accommodation stock & resettlement pathways for those leaving institutional care.
- c) Integrate diagnostics and interventions for those with autism into the existing local community service offer.
- d) Build robust transition pathways for young people identified with learning disabilities so that they remain within a supportive system.
- e) Prevent premature deaths by promoting health & wellbeing for those with learning disabilities through regular health screening, support & access to targeted training & employment.
- f) To develop a new Resource Allocation System (RAS) for LD people to demonstrate an equitable and transparent allocation of social care resources, support consistent decision making, provide a new way of measuring severity of need and support transparent care package decision making.
- g) To develop a new conversation with service users which is based around the individual and their family.
- h) To increase the number of people with learning disabilities on a coherent, coordinated and fully integrated Care Pathway.

### **3.79 Universal Offer**

- Strengthen and develop community learning disabilities health & social care teams to be responsive in supporting mainstream provision to manage those with mild & moderate learning disabilities and conditions, as well as supporting those with complex & challenging behaviours through tailored community support. The number of people who are in good quality accommodation will be increased.
- Build integrated pathways between health, social care, accommodation, education, vocation & employment agencies so that bespoke rehabilitation programmes are a fundamental element of care and support plans and people with LD are actively encouraged, trained and supported.

- Apply a single commissioning approach to ensuring robust transition and early intervention pathways with appropriate services for Children & Young People identified with learning difficulties and burgeoning disabilities, including looked after children, so that a life-course approach can be developed for each child, to reduce crises and acute episodes developing in the future.
- To improve the quality of life for people with learning disabilities and their carers. By increasing the participation of people with learning disabilities, and their carers, in the design of health and care services, by 2020 there should be a reduction of crisis hospital stays and reduction in the duration of stays

### 3.80 Primary Care Strategy

- Develop and train clinical “champions” for LD across the primary care sector developing subject matter expertise across professional footprints, including GPs, practice nurses, school nurses, dentistry, and sexual health services.
- Ensure LD register information is correct and up to date and people with LD as well as their carers receive a full annual health assessment and review.
- Work with IAPT providers to develop a specific intervention for those with LD experiencing anxiety, depression and phobias.
- Train staff from the Community Health LD team in IAPT compliant interventions for those with mild/moderate LD
- Integrate diagnostics and interventions for those with autism into the existing local community service offer.

### 3.81 Community Offer

- Redesign & reshape the Community Health LD team (formerly known as MLDP) for compliance with the national service specification including establishing specialist consultants to provide clinical leadership.
- Integrate LD social care staff including forensic staff to form a Community Health & Social Care LD team working within the One Team model as a core element of the new national service delivery model.
- Build an on-call liaison service for Accident and Emergency presentations to support Emergency Department and Mental Health liaison staff, reduce breaches and prevent unnecessary admissions, but where admission is required, it is timely and appropriately managed.
- Develop a crisis management and outreach service as part of the redesigned integrated community team that works closely with GPs, community mental health services, and social care.
- To develop a community assets approach to service delivery

### 3.82 Residential offer

- Commission a specialist residential crisis intervention service that provides respite for people with LD in order at an earlier stage and as part of an integrated community package.
- Manchester City Council and CCGs to work together to stimulate the accommodation market in Manchester to develop “step-down” residential rehabilitation for those coming out of hospital supported by community staff. Resultant increase in the number of people in good quality provision.
- Ensure all care plans and support plans include recovery and rehabilitation as part of the drive towards independent living for people with LD.
- To replace the supported accommodation estate across the City for people with a learning disability so they can live independent, supported lives in a locality of their choice in good quality apartment style provision.
- To develop a new estate for young people with a learning disability in transition from children’s to adults status, supported to live as independent life as possible to the maximum of their own ability. To promote choice about where this is located and to build a wrap around health and care model that is community based, light touch with step up levels of support when required.
- To develop more shared lives schemes and extra care facilities for people with a learning disability.

3.83 During 16/17, the commissioners will deliver the second year of their response to the learning from Winterbourne View. In Manchester there are a significant number of people with severe learning disabilities who have experienced problems which have precipitated admission to an inpatient setting for treatment. The total numbers of these patients are the highest within the Greater Manchester footprint. The Manchester CCGs and City Council therefore have a significant role to play in ensuring the safe and effective resettlement of patients from specialist hospital settings back into their own communities.

Additionally the redesign and transformation programmes taking place as part of Y1 of the Locality Plan implementation are:

- Develop a crisis management and outreach service to prevent and reduce incidents of crisis for people with learning disabilities.
- Review and redesign of community services and pathways, underpinned by integration and multi-disciplinary case management.
- Develop personalisation options for people with learning disabilities.
- Ensure step-down and rehabilitation focused accommodation is available for those leaving residential and in-patient care.
- Build robust transition pathways for children and young people with Autism and Learning Disabilities, including Looked After Children.
- Establish a specialist intervention team for people with learning disabilities showing early signs of dementia.
- Provide workforce development for staff working in primary and acute care to provide more focused support for people with LD within universal services.
- Develop a quality and outcomes framework for learning disabilities services.
- Provide support for mainstream provision for people with learning disabilities, including integrated pathways between health, social care, accommodation, education and employment agencies.

**2** Transforming  
community  
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## **Transformation 8: Health and Social Care for Children and Young People**

3.84 A review of services for children in Greater Manchester is a key element within the Greater Manchester Devolution Agreement. At a national level this review is seen as a vital piece of work and was specifically cited within the 2015 Spending Review (below) alongside the commitment to develop new approaches to investing in prevention from 2017.

*‘As a trailblazer for reform of the way that all services for children are delivered, the Government will support Greater Manchester Combined Authority to develop and implement an integrated approach to preventative services for children and young people by April 2017.’*

3.85 The review comes against a backdrop of Government wishing to drive innovation amongst authorities with growing concern nationally that the quality of services for children requires improvement, even in ‘good’ authorities. It also recognises that there are significant barriers to ‘doing things differently, which may require a change in legislation. This reflects the importance of the review of services from a national perspective.

3.86 In Greater Manchester, the imperative to look at more radical approaches to the way services for Children are delivered is acknowledged by Directors for Children's Services who also recognise that devolution must be extended to all services for children if we are to deliver the best outcomes for children within the resources available. Many areas in Greater Manchester have already developed plans to improve children’s services and reduce the number of children in care. This review will both help the implementation of their plans but also push the level of ambition.

3.87 The ambition for the review is to deliver improved outcomes for children across GM by:

**1** Radical upgrade in population health prevention

**2** Transforming community based care & support

- Improving outcomes for children and families; supporting parents and carers to be the best they can be.
- Reducing, appropriately, the number of Looked after Children – setting a high level ambition, e.g. 20% reduction in LAC.
- Reducing, appropriately, the number of Children in Need and children with Child Protection Plans.
- Developing a safe system that is financially sustainable within 5 years through joint investment of resources to reduce future demand.
- Supporting more asset based interventions to promote resilience, confidence and wellbeing in families and local communities.
- Applying a more effective organisational system in order to make best use of resources and expertise.
- Increasing social worker capability and capacity, as part of wider workforce reform and development.
- Reduction of caseload so more time can be spent with the families. Less sickness time and fewer agency staff.
- Deepening commissioning arrangements and stimulating new models of early intervention, prevention and provision.
- Learning from best practice and building on existing innovation.

- 3.88 The ambition is to develop new approaches for GM services for children that as well as significantly improving outcomes will reduce demand for high end targeted and specialist services and future pressure on a range of public service budgets. Recent analysis undertaken to support the review considered the implications of a range of different scenarios make a strong financial case for looking at new approaches to the way we deliver services for children. It shows that, across GM, demographic and other pressures will place around £40m pressures on Children's services budgets under 'business as usual' over the next 5 years. However, the analysis also demonstrates the potential of taking different approaches with four basic assumptions about reducing LAC numbers; reducing referrals, reducing external foster care spend, and reducing agency social worker spend, potentially saving £70m against the business case.
- 3.89 In addition to this important work this Plan has, in earlier sections, emphasised the following:
- A stronger approach to Early Help, with an emphasis upon prevention and tackling the health inequalities experienced by many children and young people in Manchester;
  - A strengthened approach to addressing the needs of children and young people with learning disability;
  - Service transformation to significantly reshape the way services for children and young people with mental health needs are commissioned and delivered;
  - Within the period of this Plan review the service offer to children with long term conditions and those at the end of life and palliative care.

## Transformation 9: Transforming Home Care and Residential Care

- 3.90 Providing a new model of care for vulnerable adults is a key element in ***transforming community based care and support*** within the context of our One Team model of care.
- 3.91 A key feature of our approach throughout this Plan is to promote resilience and independence, strengthening community connections and transforming models of support to divert people away from inappropriate dependence on formal health and social care.
- 3.92 The transformation of adult social care will be based upon commissioning for shared health and social benefit, will reduce demand on the urgent care system through a fundamental shift in homecare, residential and nursing home models through a diversion of current clients into existing community solutions, the significant upscaling of technology and further expansion of the 'own front door' model of supported living (see Transformation 8).
- 3.93 Delivered in partnership with GM where appropriate this priority area will seek to influence the care market offer, through stronger engagement with providers regarding our shared ambition.
- 3.94 A new model of home care will be developed with providers ensuring a higher quality of care at home is delivered by well led, trained and motivated staff. Acknowledging that homecare support and the frontline care workforce are the key interface between the most vulnerable people in the community and the health and care system, home visits gives a huge opportunity to have different conversations, connect people to their communities and deliver public health interventions in meaningful ways.
- 3.95 The ambition is to secure a transformation of homecare, with the boundary between community nursing and therapy staff and trained social care staff redrawn, liberating district nurses and other health professionals to focus on complex health needs. The aim is that the new model of homecare will reduce admissions to hospital, enabling timely discharge, reduce inappropriate use of primary care and emergency services, and enable the better use of local resources.
- 3.96 Additionally this Plan seeks to develop a reformed residential and nursing care offer for those adults unable to be supported within their own homes. Acknowledging that delayed transfers of care are significant both in financial terms in lost hospital capacity, and in terms of people's emotional and physical wellbeing, this is a priority area of focus for Manchester.
- 3.97 The ambition is for a reformed care home market to work in partnership with health providers as agents of integration supported through lead professionals working within One Team. The model of care will see care homes becoming agents of early intervention and chronic condition management, preventing the escalation of conditions and individuals entering acute settings inappropriately.

They will also become key agents in supporting timely discharge from hospital care.

3.98 During 16/17 the commissioners working with providers will:

**2** Transforming  
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support

- Engage with care providers in regarding the new model of care required.
- Develop a detailed programme for reducing delays in the transfer of care from hospital.
- Commence the development of a specification to enable procurement of the new model of care for implementation in 17/18.

## **Transformation 10: Housing and Assistive Living Technology**

- 3.99 Manchester is developing a strategic approach to meeting housing needs to maintain good health and extend independence.
- 3.100 The Housing for an Age Friendly Manchester Strategy links care and health services for our older population. Innovation, creativity and making best use of technology will increase housing provision and choices for older people. The plan is to offer older people the advice and guidance they need to make informed decisions. This is currently being tested in North Manchester. By offering Housing Options to residents approaching retirement they can be informed about lifestyle choices.
- 3.101 Extra Care housing is a type of housing for older people which offers an independent tenancy (or outright/shared ownership) within a communal setting. Onsite care is the critical feature of extra care and is strictly managed to ensure extra care housing remains a balanced community where the more active, independent older people help people who are more infirm.
- 3.102 The ambition in Manchester is to scale up future provision from the current 297 units and to provide mixed tenure options across the City. A Housing Needs Assessment has compared the forecasts of numbers of older people across the City's neighbourhoods against the locations of our existing stock and numbers of units already in a funded development pipeline. This has helped us to identify where we need to locate new developments and the numbers we need to accommodate.
- 3.103 Our ambitions are to develop an additional four new schemes over the next five years: two new schemes in the south of the City, one in the Newton Heath area and one in Gorton (already the subject of a funding bid). Subject to investment funding being available to deliver these schemes, this would provide approximately 400 additional units. We also intend to upscale some existing sheltered schemes to provide Extra Care Lite accommodation. This would bring our total extra care stock to over 1000 units. The benefits from this kind of accommodation are significant and include reduced hospital stays, reduced expenditure on adaptations in larger homes and employment and apprenticeship opportunities for the construction industry
- 3.104 The Council's Supported Accommodation Service looks after and supports learning disabled adults and learning disabled young people in transition to adulthood. The ambition is to replace or significantly improve the current estate. The design of new accommodation, tailored to the needs of each cohort will ensure better quality of care and improved lifestyle outcomes.
- 3.105 Advances in assistive technology, and tailored equipment packages will support greater independence and deliver more cost efficient packages of care. Assistive Living Technology (ALT) includes both telecare and telehealth/telemedicine. The ambition in Manchester is to roll out ALT across the whole City to other cohorts as a prevention tool to reduce unplanned hospital admissions and as a way of shifting the appropriate delivery of care

from acute hospitals to community settings, particularly people's homes. There is a real opportunity to involve private sector expertise and investment.

- 3.106 There are clear advantages for supported living arrangements that offer choice and independence. This can also maximise opportunities to link to education and employment and to develop independent living skills. Investing in appropriate accommodation and services will enable young people to live inclusive lives within their communities. Ideally people will be able to live more independently without 24 hour support, reducing care costs further.
- 3.107 Improvements to the City's aids and adaptations services will be essential if our LLLB programme is to work. People need suitably adapted homes to return to following a stay in hospital. To improve these services, we will:
- Develop a social care cluster of equipment related services in one centre of excellence across local authority and health budgets.
  - Develop a partnership approach across the local authority, health, housing providers and the third sector for adaptations to people's homes so that they can continue to live in them for longer, delaying costly placements in residential and nursing homes.
  - Develop a unified approach to rehousing people.

3.108 Specifically in 16/17:



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- Align and shape housing related support provision for mental health across the city to ensure that there is a clear pathway and provision offer from acute settings to independent community living.
- Proceed with an Extra Care procurement of Village 135 for older people
- Develop a new housing in partnership with RP's for LD Adults (40 flats at 2 sites) and young people in transition (30 flats at 3 sites)
- Secure GM Investment for scale up of Assistive Technology

## **Transformation 11: Standardising Acute Hospital Care - A Single Manchester Hospital Service**

- 3.109 A key element of the Locality Plan is work underway to ***standardise acute hospital care*** in Manchester. The hospital services in Manchester include some of the best and highly regarded teams in the UK, with real areas of excellence in clinical care. However, there are also significant inconsistencies and variations in the way that acute hospital services are provided at present. Standards of care can be variable, best practice is not consistently adopted or adhered to, and there are important gaps in services alongside areas of service duplication. The existing arrangements also fail to provide a clear Manchester focus for acute hospital care, or for the relationship between providers and commissioners.
- 3.110 The partnership working approach, including Central Manchester University Hospitals NHS Foundation Trust (CMFT), University Hospitals of South Manchester NHS Foundation Trust (UHSM) and Pennine Acute Hospitals Trust (PAHT), would aim to deliver consistent and complementary arrangements for providing acute hospital services across Manchester. The aim is ultimately to achieve a fully-aligned hospital model.
- 3.111 It is proposed to create an appropriate mechanism to bring together the organisation and delivery of acute hospital services through a two stage process. On this there are 2 interconnected work-streams – A Single Hospital Service Review, and the North East Sector Review. The former is reviewing clinical services offered by the acute sector within the City, and the latter is focusing upon the range of acute and community services provided in the north of the City, and beyond encompassing the towns of Rochdale, Oldham and Bury.
- 3.112 Firstly, the review(s) will involve reviewing the service portfolios of the three Trusts and developing a detailed exposition of the potential benefits of a fully aligned hospital service model, expressed in terms of clinical, patient, staff, financial, research and innovation aspects, and fully supporting integrated working.
- 3.113 Secondly undertaking a detailed appraisal of the most appropriate governance arrangements, including:
- The overall organisational governance which will bind all three acute providers in the City of Manchester into a set of formally agreed accountability arrangements, with devolved authority from each of the three respective Boards;
  - The structure and operation of any supporting governance structures, for example a Joint Hospitals Board;
  - The key supporting workstreams (focussed on priority areas for developing clinical single services);
  - The arrangements for management of operational services; and
  - The contractual arrangements with commissioners, including the management of risks and benefits, which will need to provide assurance to

commissioners that the delivery arrangements have a binding and accountable point of authority.

3.114 At the heart of the clinical service modelling would be the development of a series of 'single services' for acute hospital care in Manchester. This work will build on the approach utilised for Healthier Together, and would be driven by clinical standards developed through discussion and agreement amongst clinical teams. However, the service scope will be much more ambitious than Healthier Together, progressively encompassing all acute hospital services.

3.115 It would be expected that a fully aligned hospital service model could be progressively developed and implemented by April 2020, while recognising that any capital or estates development may also need to be considered.

3.116 Specifically, in 16/17 the following will be the focus:



- Implementation of a single hospital service for Manchester, following a benefits assessment and the development of new organisational and governance arrangements.
- Implementation of Healthier Together for emergency and complex abdominal general surgery
- Implementation of the outcomes from the North East Sector Review

## **4. Enabling Better Care**

### **The Manchester Locality Care Organisation**

- 4.1 The place based model of care delivered through the Living Longer Living Programme, is a collaborative venture of health and care providers in the City. In order to secure optimum benefits from this model of care the commissioning organisations have determined that a single contract will be let to a single entity in the City. In this way, variation in the delivery and access to services can be reduced, with consistency delivered where appropriate and inequalities continued to be tackled. In their response the provider organisations have determined that they will collaborate in the delivery of the requirements of the single contract, and that this collaboration will take the form of a special purpose vehicle termed a Locality Care Organisation.
- 4.2 The Locality Care Organisation will be a legal entity which will hold the contract issued by commissioners and be held to account for the delivery of the outcome measures specified within it. Through the contract it will commit to delivering specific outcome based targets required to meet the objectives of this Locality Plan, and it will agree to deliver those targets within an agreed financial settlement.
- 4.3 The Locality Care Organisation will oversee (via a contracted relationship) delivery of the necessary outcome based targets at the neighbourhood level. 12 neighbourhood teams delivering the new model of care will serve a population of approximately 30 - 50,000 patients/residents.
- 4.4 Work is underway exploring the appropriate legal form required for the LCO to accommodate the functions.

### **The Single Commissioning Function**

- 4.5 In order to ensure the efficient commissioning of health and social care services on a city wide basis the 4 commissioning organisations across the City, (Manchester City Council, South Manchester CCG, North Manchester CCG and Central Manchester CCG) have embarked on a programme to integrate commissioning capacity, functions and resources.
- 4.6 The programme, 'Working Better Together', will initially focus upon working towards more formalised joint commissioning between health and social care progressing towards an integrated model in the medium term. Work programmes will be to a Manchester model, although there will be variations of geography and approach to implementation based upon the priority area. The aim of the programme in the first instance is to make changes which will ensure we are effective commissioning organisations, working as a common function to a common plan. The focus is on the short to medium term (0-2yrs) but also starting an evolution to what they likely longer term position will be.
- 4.7 These changes need to create a single commissioning function for Manchester which means:

- A common plan, commissioning approach and mechanisms to commission for Manchester.
- To make sure that commissioners use the collective resource (via a pooled budget) to the best possible effective in implementing the Manchester Locality Plan and delivering upon operational and statutory duties.
- To ensure stability within the organisations to ensure effective working and good governance within and across organisations.
- Ensure that the CCGs and the City Council retain the strengths of their existing working relationships e.g. CCGs have a strong view that clinical leadership and connectivity at the local level have been the key success factors for the CCG model of commissioning.
- To create stability within the organisations to ensure effective working and good governance.
- To ensure equity e.g. distribution of resources across the City i.e. a distinction between CCG allocations across the city.

4.8 In order to support development and delivery of the Plan through the deployment of pooled arrangements with the objective of securing a shift of resources, progress with implementation and delivery will be analysed during each phase in order to establish:

- A definition of patient/client populations affected, together with detail of how people meeting that definition will be identified.
- An estimate of the numbers of the people within the cohort across the City over the next five years
- A systematic evaluation of the costs and benefits of the new service models, in comparison to the existing arrangements.
- An overall assessment of the financial implications of these changes for the various partner organisations and the supporting mechanisms required to move funding around the system.

### **Health and Social Care Estate Transformation**

4.9 A City wide estate strategy is crucial to deliver efficiencies, to provide the right buildings for integrated care and to enable the City to plan its wider land use to facilitate growth and housing for an expanding population. GM devolution of health and social care, coupled with the proposal for a GM Land Commission announced as part of the devolution package in the July 2015 budget create the opportunity for a radically different way of managing property and other assets. Within Manchester this will involve a portfolio of well located, high quality accommodation that could be coordinated and utilised more flexibly.

4.10 The current estates provision across health and social care is extremely complex. The complex nature of financial arrangements for NHS estates needs to be addressed at a GM and Citywide level. Key to this will be releasing resources from existing properties to re-invest in accommodation for the new hub based delivery of community services across Manchester.

- 4.11 A Citywide Integrated Estates Development Board is in place which comprises of members from the health and social care system across Manchester. This board will develop the City wide estates strategy, assess current estates provision and develop an estates portfolio which will support the health and social care transformation programmes across the City.
- 4.12 In line with the delivery of One Team, the vision has been developed to provide 12 multi-disciplinary Place Based Hubs throughout Manchester. The hub and spoke model will be operated with the hubs being at the centre of a network of community assets or spokes. The hubs will provide accommodation for teams working beyond organisational boundaries to deliver public services designed around people and place not organisation and team, a focal point and facility for the community, increasing access to service provision, and having a role to improve health, wellbeing and quality of life within the area in which they are based.
- 4.13 There will need to be some investment in the community based estate, to support implementation of the model and some limited new build where required; but there are also major opportunities to develop efficiencies through better utilisation and more integrated working.

#### **Information Management and Technology – Shared Records and Digital Wellbeing**

- 4.14 To deliver the ambition set out in section 1.5, a radical approach to identifying patients and tracking them through the system, sharing electronic records and adopting a digital approach to wellbeing is essential. There are 5 key areas of work to be done:
- There are some immediate tactical solutions that are required to support the initial integration of community health and social care.
  - A longer term strategic approach to deflection from hospital admissions and residential care placements through the development of a citywide Patient Co-ordination Centre and electronic system.
  - To develop a wider Digital Wellbeing approach to integration with a scaling up of approaches such as telemedicine to deflect hospital and residential care admissions.
  - To develop significant IMT partnerships with the private sector including the promotion of Manchester as a centre for inward commercial development and a test bed for IMT innovation.
  - To scope out and recruit a delivery team for the work led by UHSM.
- 4.15 Tactically, solutions are required for the three community health services to procure electronic case management systems that are interoperable with social care, primary care and other hospital sectors. The PDT requires solutions to enable them to share files across organisational systems and there is potential for teams to adopt the NHS email platform. Integrated estates require wifi options so staff can connect in as they work in between buildings and sites. North Manchester has developed a tactical approach to interoperability between Community Services and Social Care for referrals and workflow and there are similar requirements across the rest of the City.

- 4.16 The social care record system will be upgraded to enable further interoperability and compliance with the Care Act which will include provision for a citizen portal, electronic marketplace, commissioning directory of services and resident facing electronic care accounts and social care support plans
- 4.17 Strategically, work is required to drive the urgent need to identify people early who are at risk from a hospital or residential care admission. An electronic patient co-ordination system to support risk stratification and patient tracking is required citywide which will work across all parts of the model including primary care, social care, community health, public health, hospitals and ambulances. This needs underpinning through access to electronic records and work is needed to decide whether to further develop the common feed into the Manchester Care Record or to look for a new solution. In the short term, we will incorporate into the MCR the mental health record, add an application to support end of life care and extend access to ambulance services and A&E departments in the event of emergency.
- 4.18 A wider Digital Wellbeing Strategy will be developed alongside the Self Care Strategy to include developing digital health solutions to deliver technology first services arising from the risk stratification work. For example, telemedicine hub for residential and nursing cohort, heart monitors for circulatory disease, GPS locators for people with dementia, falls monitors for frail older people etc. The telemedicine work could be applied at scale across GM.
- 4.19 There are opportunities arising to develop strategic relationships with private sector IMT companies who will see Manchester as a test bed site for new innovative solutions. Opportunities will be sounded out at the September Expo and trade fair supporting the Tory Conference in October. Early meetings with Cisco Systems have already taken place
- 4.20 To deliver such an ambitious programme of work, a delivery team will be required. UHSM have agreed to lead this and work is underway to scope out the business requirements and secondment requests from the Manchester providers.

### **Workforce Transformation**

- 4.21 We have made significant progress against our ambitions for health and social care reform in recent years within Manchester. An increase in people benefiting from extended access to primary care, models of integrated neighbourhood working between health and social care are coming to life across all parts of Manchester.
- 4.22 We are re-imagining health and care and pursuing entirely new possibilities for specialist care, integrated care, primary care, early intervention, prevention and wellbeing services.

- 4.23 The scale of change we propose will impact significantly on our way of working, challenging traditional roles, introducing new relationships, new teams and indeed new professions. Whilst the vision for integrated care delivery is clear in Manchester through the Living longer Living better programme with early pilots generating confidence in the potential for the new models, delivery of the road map will require very significant cultural change and involvement of the workforce across many organisations.

*Strategic Workforce Aims*

- 4.24 Future care models such as those outlined on the NHS 5 Year Forward view and as described in recent King's Fund reports all emphasise the centrality of primary and community care, and a more adaptable and multidisciplinary workforce. We need a workforce for the future that:

- Is empowered and flexible.
- Will work across both organisational and geographical boundaries.
- Is fit for purpose.
- Is sufficient and capable of providing high quality care at the point of need.

- 4.25 A strategic workforce plan for Manchester will be put in place providing the basis for specific long, medium and short term objectives in relation to:

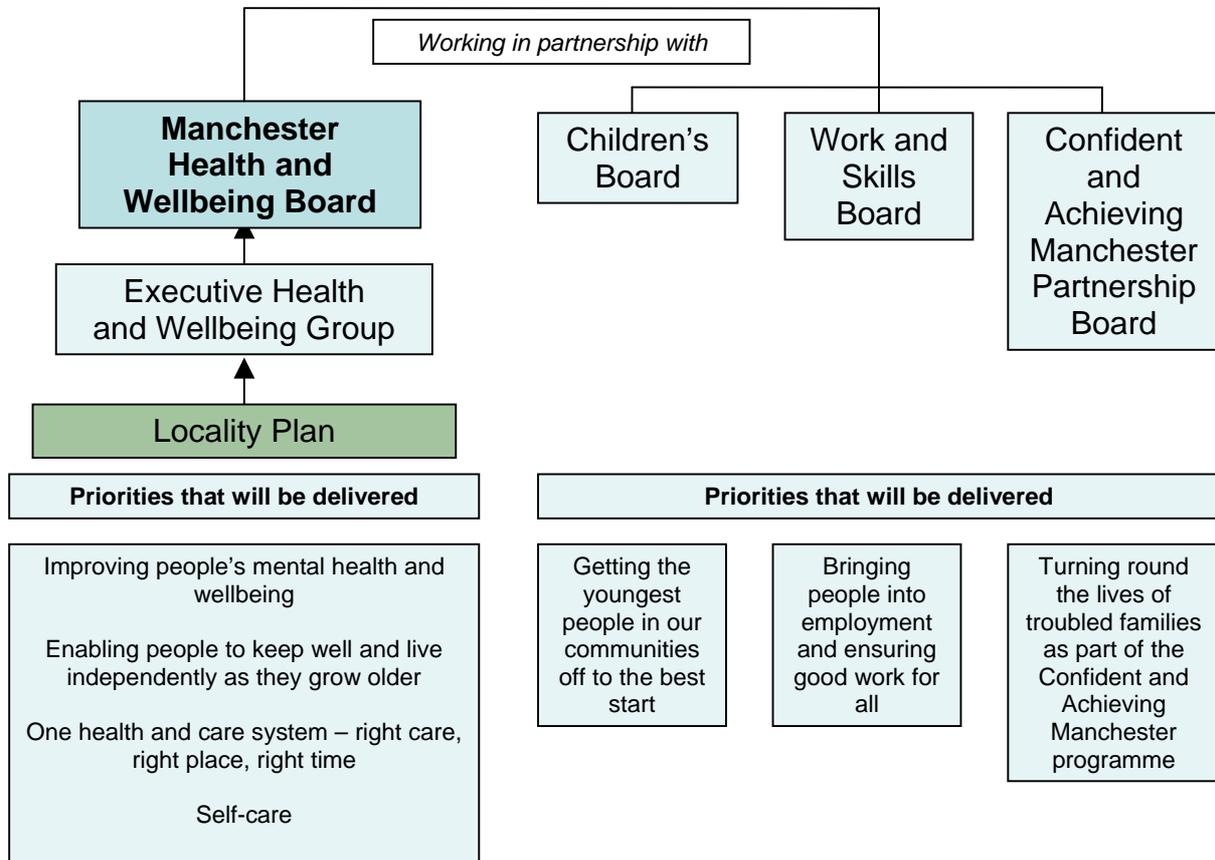
- Communication of strategic vision/intent.
- Education and commissioning to include the development of partnership working arrangements between Health Education Northwest, Skills for Health and Skills for Care and the GM Academic Health Science Network in order to ensure one Manchester health and social care workforce plan. This will inform the commissioning of new education programmes to support new models of care.
- Workforce profiling and future planning including role re-design and competency based planning within multiagency, multi-disciplinary environments with a focus on people, place and outcomes.
- Terms and Conditions of employment across partner organisations to:
  - increase recruitment from local communities and progress further work to ensure that workforces reflect the communities they serve;
  - incentivise employment conditions which promote good health e.g. payment of living wage opportunity for home care and residential care home staff, organisations providing a healthy workplace.
- Cultural change and organisational development with programmes designed to shift control from doing to people and supporting them to be active participants in managing their own care.
- Development of joint working with NHS and City Council/trade unions and a single TU consultation and negotiation strategy to deliver Health and Social Care reform across Manchester.
- Development of a Manchester Workforce Leadership Group to secure partnership working and system leadership across health and social care.
- Alignment with other key NHS and Social care strategic organisational changes for example, Healthier Together, Placed Based Care, Primary Care Transformation.

- 4.26 The scale of change within Manchester will impact significantly on the workforce. Workforce planning is important because of the complex skill-mix required. We need a workforce that is fit for purpose, able to adapt to changing demographics and the new models of care. Building a more flexible workforce with a breadth of skills and knowledge allows for greater adaptability.
- 4.27 Although it is vital to get the workforce of the future right, there also needs to be a clear plan for how the current workforce can meet the challenges ahead. This will involve a more integrated approach to managing the existing workforce.
- 4.28 Specifically in 2016/17 we will be focusing on:

## 5 Enabling better care

- Through 'Working Better Together':
  - the development of a single commissioning system for community health and care services to support the mid-year roll out of neighbourhood health & care teams.
  - the alignment of workforce, and development of 'matrix working' to deliver of our transformational programmes.
- Develop a citywide estates strategy and local implementation plans.
- Implement a citywide estates model in line with the One Team specification.
- The rollout of the Manchester Care Record to all provider organisations and extend its use to all patients identified as frequent users of secondary.
- Further development of the Manchester Care Record to ensure its functionality supports the development of the One Team approach.
- Implementation of primary care workforce strategy.

**Appendix 1 – Delivering the Health and Wellbeing Strategy**



## Appendix 2 – Financial Plan

### 1. Financial plan

- 1.1 The strategies described in this plan represent Manchester’s health and care partners’ agreed approach to managing a predicted ‘do nothing’ deficit of £284m by 2020/21 for the scope of services and responsibilities for Manchester listed in Tables 1 and 2 below.
- 1.2 The forecast deficit rises to £373m, an increase of £89m, if estimates for specialist services are included within the Manchester financial model.
- 1.3 A summary financial plan for the five years from 2016/17 to 2020/21 has been projected for Manchester, taking account of pressures and demographic changes over the period, together with estimated changes in resources for health and social care. The deficit originates from net estimated financial challenges across health and social care of £163m and £121m, respectively.
- 1.4 Modelling suggests that by 2020/21, Manchester will have:
  - an increase in health and care expenditure of £297m (Figure 1/Table 4).
  - an aggregate total increase in health and social care resources of only £13m (Figure 1/Table 4).
- 1.5 It is recognised that a deficit of this magnitude will only be avoided through strong partnership working and by jointly transforming the future of health and care commissioning and provision, to create a clinically and financially sustainable system.
- 1.6 Partners are committed to achieving and demonstrating clinical sustainability and improved quality outcomes from the future health and care system, whilst managing patient and resident needs within available resources. Partners have agreed to the principle that the delivery of transformation programmes will enable a shift in resources between hospital and community settings.
- 1.7 Applying the Greater Manchester savings opportunities identified within the CSR submission to Manchester, indicates that Manchester has the **potential** to convert the significant ‘do nothing’ deficit of £284m to a £21m surplus (or contingency) by 2020/21 (see Table 5).

### The Financial Model

- 1.8 Financial modelling has been undertaken to calculate a five year health and care financial plan for Manchester for the years 2016/17 to 2020/21, incorporating:
  - i) sources of pressures within the economy, analysed by sector, using:
    - a series of strategic financial planning assumptions derived from the ‘Five Year Forward View’; and
    - health and social care expenditure baselines for the **Manchester population** within the scope of Manchester’s local responsibility under GM Devolution, including:

- £1.1 billion of 2015/16 commissioning budgets for the three Manchester Clinical Commissioning Groups, NHS England (for primary medical services) and Manchester City Council (children's and adults social care) – see Tables and 2; and
  - £0.6 billion of 2014/15 outturn income and expenditure, excluding estimates for specialist services, for the providers shown in Table 3.
- ii) assumed funding commitments from the Treasury with respect to the protection of health and care in Manchester;
- iii) potential commissioner benefits using GM wide assumptions or locally estimated benefits assumed to be achievable through the commissioner led strategies described in this plan

<b>Table 1 – 2015/16 Commissioning Baseline Budgets by Commissioner</b>	<b>Opening expenditure values 2015/16 £m</b>
North Manchester CCG	274.4
Central Manchester CCG	252.4
South Manchester CCG	223.2
<b>Subtotal – CCGs</b>	<b>750.0</b>
NHS England ( <b>Note 1</b> )	70.9
<b>Subtotal – Health</b>	<b>820.9</b>
<b>Manchester City Council</b>	<b>301.1</b>
<b>Total - Health and Care Resources in Scope</b>	<b>1,122.0</b>

**Note 1:** Reflecting medium term commissioning responsibilities, NHS England's Direct Commissioning budgets for the following services are **excluded** from Manchester's analysis and financial modelling: circa £67.8m for secondary care dental, primary care dental, primary care ophthalmic and primary care pharmacy services, in addition to an estimated £220.5m for specialist hospital services.

<b>Table 2 – 2015/16 Commissioning Baseline Budgets by Service Area</b>	<b>Opening expenditure values 2015/16 £m</b>
Acute	374.4
Mental Health	104.3
Community Health	66.8
Continuing Care	36.7
Primary Care	8.8
Prescribing	91.0
Other Programme	50.4
Other	17.6
<b>Total – CCGs</b>	<b>750.0</b>
Primary medical services (assumed delegated to CCGs from 2016/17)	70.9
<b>Total – NHS England</b>	<b>70.9</b>
<b>Total – Health</b>	<b>820.9</b>
Adult Social Services	53.2
Learning Disability	49.9
Public Health	48.3
Mental Health	20.6
Children's Social Services	96.0
Complex Dependency	13.4
Other Commissioned Services	9.3
Administration	10.3
<b>Total – Manchester City Council</b>	<b>301.1</b>
<b>Total – Health and Care Resources in Scope</b>	<b>1,122.0</b>

<b>Table 3 – 2014/15 Provider Baselines within the Financial Model (adjusted to exclude 'non-Manchester flows' and specialist services)</b>	<b>Income 2014/15 £m</b>	<b>Expenditure 2014/15 £m</b>
Manchester Mental Health and Social Care Trust	85.8	86.9
Central Manchester University Hospitals Foundation Trust	205.4	206.8
Pennine Acute Hospitals Trust	108.2	107.0
University Hospital of South Manchester Foundation Trust	111.1	108.7
North West Ambulance Service	15.7	15.6
Other providers	50.9	50.8
<b>Total</b>	<b>577.1</b>	<b>575.9</b>

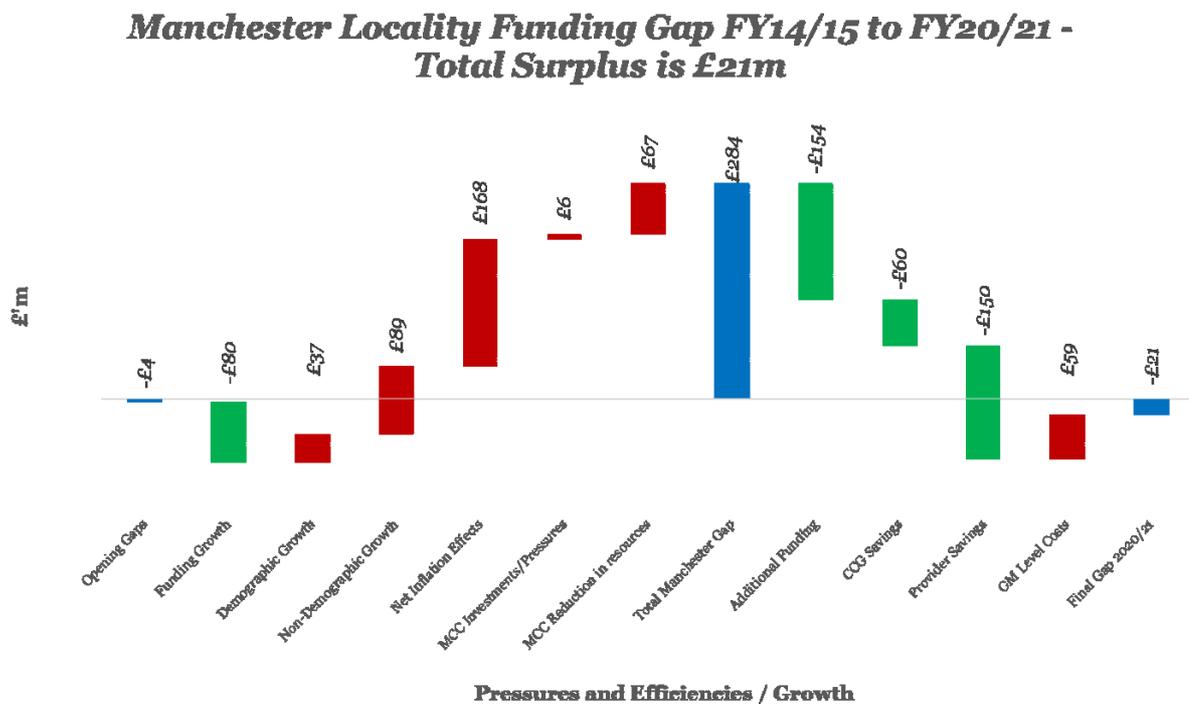
1.9 Using the baselines in Tables 1 to 3 and key assumptions about price and cost inflation, growth, and funding changes, variations of the financial gap and potential mitigating opportunities have been modelled and summarised in a series of 'bridge charts', the outputs of which are explained below.

**The 'do nothing' deficit: £284m**

1.10 Figure 1 illustrates Manchester's population based share of pressures arising from services and budgets within scope for the Manchester Locality under GM Devolution, i.e. **excluding specialist hospital and non-medical primary care services. The resulting gap of £284m is the local five year efficiency target for the purposes of this plan.**

1.11 The chart also summarises the impact of benefits modelling under the Upside Scenario (explained later).

**Figure 1 – Manchester Pressures and Upside Benefits to 2020/21**



1.12 Further analysis of the data in Figure 1 by sub-sector of the Manchester economy demonstrates that the forecast deficit relates to health and social care services over the five year period as shown in Table 4:

Table 4 – Analysis of 'do nothing' gap	Total	Health	Care
	£m	£m	£m
Opening position	-4	-4	
Net demographic pressures	37	26	11
Non-demographic pressures	89	52	37
Inflation	101	101	

Tariff deflation	68	68	
MCC Pressures	6	0	6
<b>Net cost pressures</b>	<b>297</b>	<b>243</b>	<b>54</b>
Increase in CCG funding	-80	-80	
Social care funding reduction	67	0	67
Funding change	<b>-13</b>	<b>-80</b>	<b>67</b>
<b>Total do nothing gap</b>	<b>284</b>	<b>163</b>	<b>121</b>

### Achieving financial sustainability – benefits identification and quantification

1.13 Alongside the pressures illustrated in Figure 1, benefits have also been modelled to show the impact upon the deficit over the five year planning period.

1.14 A share of GM ***‘potential opportunities’***, scaled to Manchester’s population, has been calculated using the assumptions set out in the ‘GM Strategic Financial Framework’ which are designed to lead to financial sustainability for providers and commissioners by 2020/21 (see Table below for definitions).

#### GM Strategic Financial Framework definitions:

1. Prevention	2. Better Care	3. Provider Reform	4. Enablers
<ul style="list-style-type: none"> <li>Reduce prevalence</li> <li>Deliver wider economic benefits e.g. employment</li> </ul>	<ul style="list-style-type: none"> <li>Reduce bed-based activity</li> <li>Increase independence and deliver better outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Reduce unit cost</li> <li>Implement new ways of delivery</li> </ul>	<ul style="list-style-type: none"> <li>Enable transformations and growth</li> </ul>
<ul style="list-style-type: none"> <li>A. Starting well to embed health lifestyles</li> <li>B. Living well to support prevention</li> <li>C. Ageing well to keep older people healthier and independent for longer</li> <li>D. Nurturing a Social Movement for Change to encourage people to support each other</li> <li>E. Wider public sector reform to improve the lives and prospects of the population</li> </ul>	<ul style="list-style-type: none"> <li>A. Self-care to better manage health conditions and minor ailments</li> <li>B. Reduce admissions to hospitals and care homes through coordinated care</li> <li>C. Supporting families to live healthy, productive lives</li> <li>D. Optimising elective care</li> <li>E. Discharge, reablement and supporting independence to keep people at home and reduce admissions</li> <li>F. End of life care to support people to die in the way they wish</li> </ul>	<ul style="list-style-type: none"> <li>A. Productivity including labour productivity, agency, procurement and estates</li> <li>B. Revenue optimisation</li> <li>C. Community-based provider models</li> <li>D. Acute-based provider models including consolidation of clinical services</li> <li>E. Integration models including MSCP, PACS and chains</li> <li>F. Life sciences growth</li> </ul>	<ul style="list-style-type: none"> <li>A. Estate optimisation and release</li> <li>B. Information and IT to support new delivery models</li> <li>C. Payment method including capitation and primary care</li> <li>D. Workforce pump priming and development</li> <li>E. Organisational development to support new delivery models</li> </ul>

1.15 Benefits models are shown for two scenarios: A) Upside and B) Downside. The key differences between the two are (all other assumptions remain consistent):

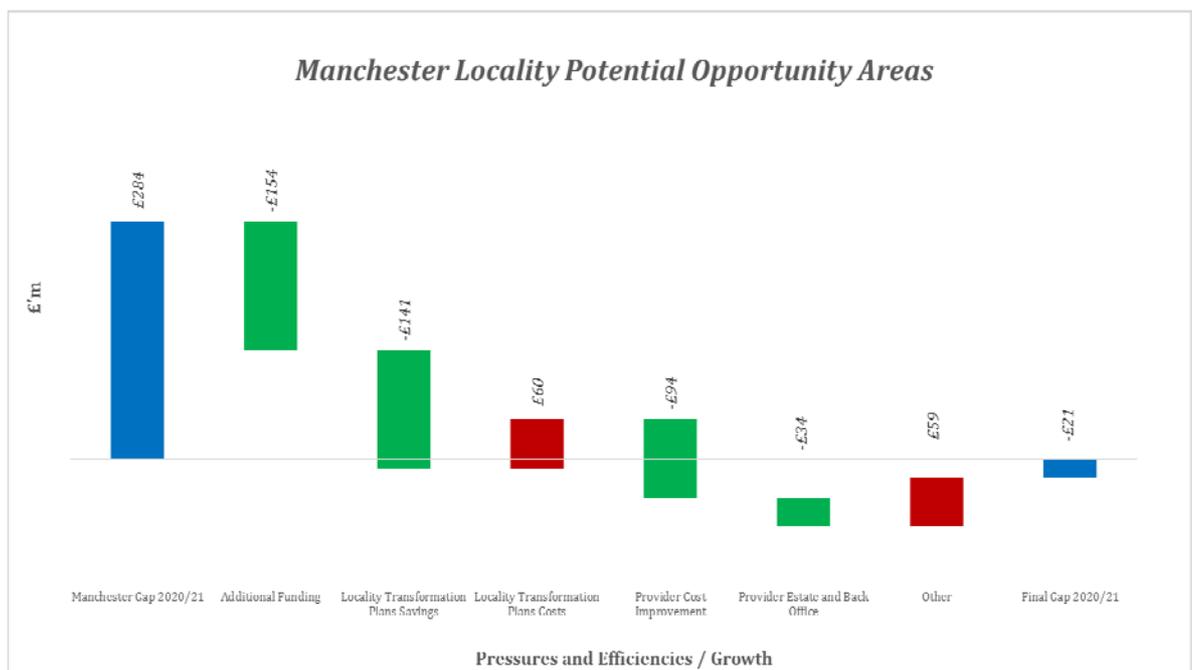
GM Assumption	Upside	Downside
Share of £8bn NHS Funding	100%	50%
Protection of Social Care Funding - £67m	100%	0%
Provider Cost Improvement Plans	2.5% Year 1-2 2.0% Years 3-4	0.8% p.a.

### A) Upside Scenario

- 1.16 The output of this model (Figure 2) identifies potential – **but highly ambitious** – benefits for both commissioners and providers:
- £81m relating to Locality Plan Transformational Schemes net of re-provision costs; and
  - £128m for other GM led programmes (see Table 5).
- 1.17 The model assumes £154m of additional funding over the five year period, reflecting:
- £67m for the ‘protection of social care’ requested through GM Devolution; and
  - £87m for the three Manchester CCGs, representing a share of the £8bn additional national funding announced through the Government’s 2015 manifesto commitments to the NHS.

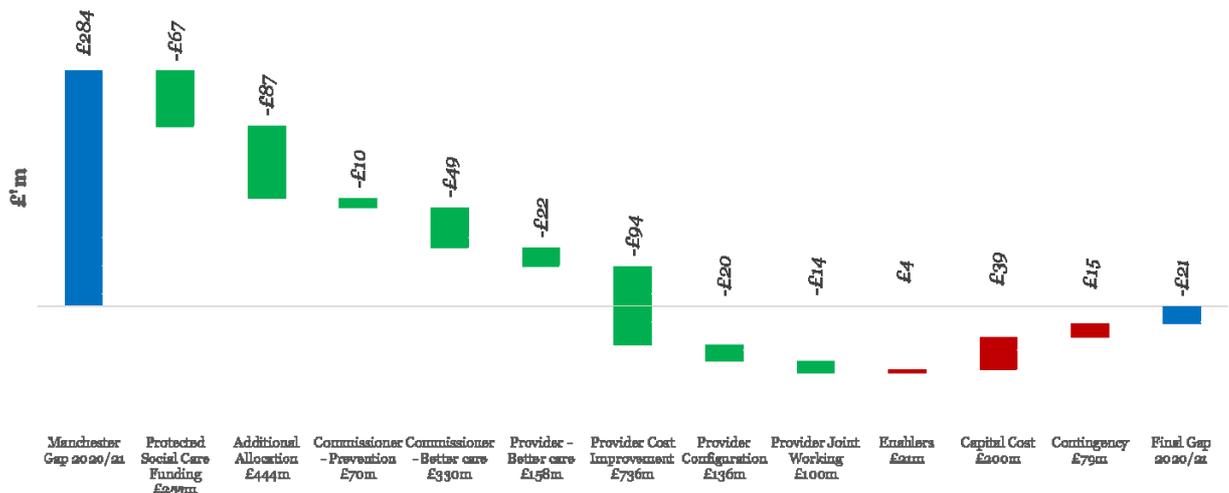
**Figure 2 – GM assumptions of potential opportunities, scaled to Manchester**

- 1.18 Manchester’s population based shares of GM estimated opportunities are shown in the bridge chart below:



This is further analysed in the bridge chart below:

**Manchester Locality Potential Opportunity Areas**



**Pressures and Efficiencies / Growth**

1.19 The assumptions in these charts indicate that the economy will be in overall surplus by £21m by 2020/21.

<b>Table 5 – GM Benefits Analysis by 2020/21</b>		<b>Total</b>
		<b>£m</b>
Do nothing gap 2020/21		<b>284</b>
Additional Funding		-154
Net Locality Transformation Plans		-81
Provider Cost Improvement		-94
Estate and Back Office Transformation		-34
Other		58
<b>Closing surplus position</b>		<b>-21</b>

1.20 Other than the material funding assumptions described in 7.16, key assumptions underpinning the estimated benefits in Figure 2 include:

- £94m of assumed provider savings, representing assumed **net efficiencies of 2.5% in 2016/17 and 2017/18 and 2.0% in the remaining three years** of the planning period. (This compares to an historic 0.8% efficiency actually delivered across the NHS.); and
- the costs of re-commissioning alternative care models will be 50% of amounts saved.

1.21 Further work will be carried out to verify the deliverability of the GM efficiency assumptions and reasonableness of re-commissioning costs across Manchester’s partners by the end of November 2015.

## B) Downside Scenario

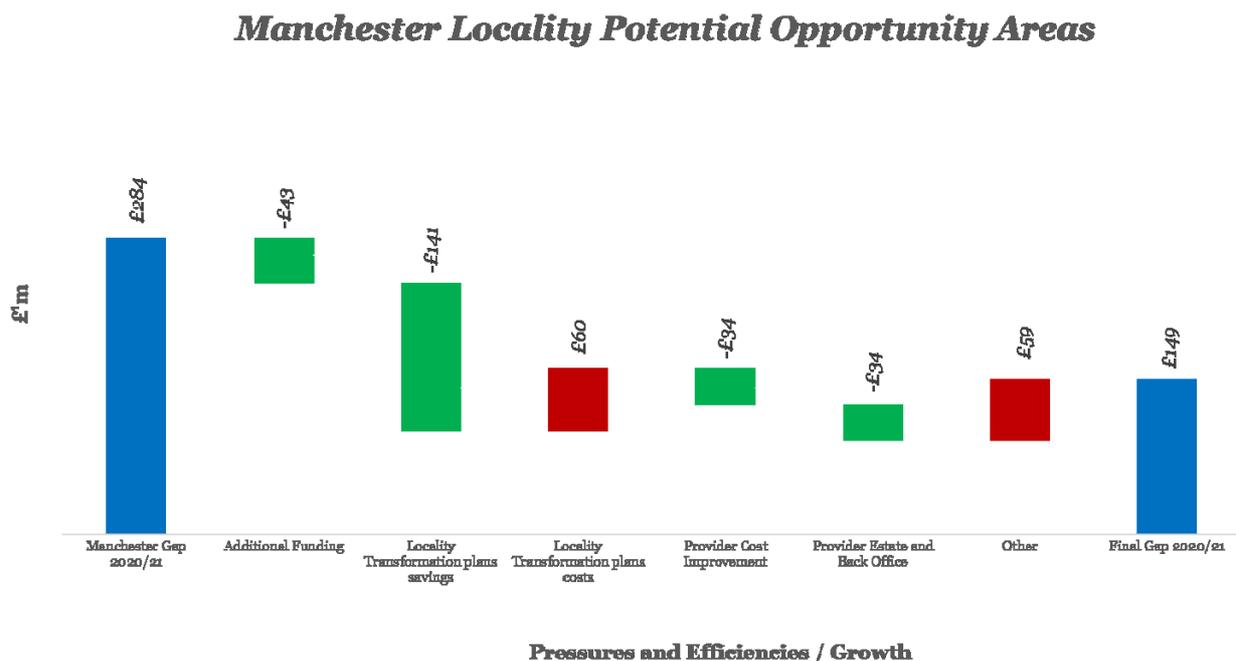
1.22 Local assumptions have been applied within this scenario to illustrate the risks associated with the optimistic GM upside scenario in Figure 2. The output of this model (see Figure 3) identifies potential benefits for commissioners and providers of:

- £81m relating to Locality Plan Transformational Schemes net of 50% re-provision costs; and
- £10m for all other GM led programmes (see Table 6).

1.23 Furthermore, this model assumes only £43.5m of additional funding over the five year period, reflecting:

- No 'protection of social care' funding requested through GM Devolution; and
- £43.5m for the three Manchester CCGs, representing only a 50% share of the £8bn additional national funding announced through the Government's 2015 manifesto commitments to the NHS.

**Figure 3 - Potential opportunities - downside scenario**



1.24 The downside scenario shows the impact associated with under-delivery against the GM modelled opportunities, as the economy's overall position converts to a deficit of £149m by 2020/21 (instead of a surplus of £21m under the 'Upside Scenario'):

Table 6 – GM Benefits Analysis by 2020/21	Total
	£m
Do nothing gap 2020/21	284
Additional Funding (partial NHS only)	-44
Net Locality Transformation Plans	-81

Provider Cost Improvement	-34
Estate and Back Office Transformation	-34
Other	58
<b>Closing deficit position</b>	<b>149</b>

### Local planning

- 1.25 For the purposes of this plan and despite the delivery risks associated with the GM assumptions in the 'Upside Scenario', **the focus in Manchester for transformational savings is the £81m challenge relating to the 'Locality Transformation Plans'** estimates in Tables 5 and 6.
- 1.26 Similarly, although the range of savings within 'Provider Cost Improvement', 'Estate and Back Office Transformation' and 'Other' is materially different in each scenario, it is assumed for the purposes of this plan that solutions will be developed through other GM and provider channels to identify the remaining £128m of savings shown in the Upside Scenario.
- 1.27 Very early 'bottom up' analysis of the potential benefits relating to each of the transformational programmes included within the locality plan, shows that proposals are being developed which currently indicate that up to £48.6m of savings may be possible by 2020/21, falling £32.4m short of the £81m of savings required across Manchester by 2020/21. These are summarised in Table 7 (values are cumulative).

<b>Table 7 – Benefits Realisation by Programme</b>	<b>Cost</b>	<b>Benefit</b>	<b>Net</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>
Mental Health Improvement	0.0	-14.1	-14.1
Learning Disabilities	0.0	-7.4	-7.4
Community Intermediate Care and Reablement	37.9	-44.8	-6.9
Manchester Neighbourhood Care	19.1	-38.3	-19.1
Urgent Care First Response	1.8	-9.7	-7.9
Extra Care Housing	9.3	-10.6	-1.3
Primary Care	10.0	0.0	10.0
Cancer Improvement Programme	6.4	-8.3	-1.9
<b>Totals</b>	<b>84.5</b>	<b>-133.1</b>	<b>-48.6</b>

- 1.28 Local plans will be reviewed and adjusted accordingly because the financial affordability assessment in each financial year from 2016/17 to 2017/18 across the economy requires action to be taken to bring partners into balance.
- 1.29 Local strategic financial planning and analysis will be used to calculate target efficiency requirements for transformational plans to meet the efficiency requirement of £81m. When compared to the values estimated as possible through early bottom up modelling, this gives a level of stretch and/or

additional savings targets across the programmes and broader health and care budgets (see Table 8).

<b><u>Table 8 – Locality Plan Transformation</u></b>	<b>Benefits estimates £m</b>
Mental Health Improvement	-14.1
Learning Disabilities	-7.4
One Team - Community Intermediate Care and Reablement	-6.9
One Team - Neighbourhood Care	-19.1
One Team - Urgent Care First Response	-7.9
Extra Care Housing	-1.3
Primary Care and Prescribing	10.0
Cancer Improvement Programme	-1.9
<b><u>Sub-total</u></b>	<b>-48.6</b>
Additional savings requirement to achieve assumed GM benefits	-32.4
<b>TOTAL</b>	<b>-81.0</b>
<b><u>Potential other programmes / budgets:</u></b> Care Closer to Home Children and Young People Continuing Care Early Years Public Health Review Administration Other hospital care	

### **Cost Benefit Analysis**

- 1.30 Further financial modelling is required to determine the costs and benefits of the above transformation plans which will be undertaken. This will show the recurrent and non-recurrent investment requirement for new models of care and targeted impact from reductions in acute hospital and residential care home activity. This will be informed by the local CBA undertaken in Manchester based on emerging care models, learning from other GM localities, national and international evidence, and stretch targets from GM transformation initiatives.
- 1.31 To meet the efficiency targets identified in the bridge charts above, a significant amount of work is still required to define how Manchester's transformational plans and other programmes of work will deliver the savings required. This must focus upon describing, in financial terms, how the new models of care will be different to the current health and care model.
- 1.32 Providers and commissioners are working together to develop and implement a monitoring and evaluation process to track actual costs and financial

benefits for the change programmes described in this plan. This will including tracing the impact of investments to reductions in activity levels (and hence cost drivers), including where and when those reductions lead to savings in other parts of the system. This monitoring and evaluation process will be used to manage risk and ensure that the agreed shifts in resources are achieved over the five year period.

- 1.33 The proposals being developed by providers will also include CBA requirements to set out clearly what interventions will be carried out, the activity and the expected outcome in the form of a reduction in demand. The CBA will require work-stream leads to estimate the cohort and likely outcomes so that it can be compared to what is being provided at the moment. The current position 'Business as usual' will be compared to the outcomes expected in the future 'New Delivery Models'.
- 1.34 The models must be shared and 'owned' by all partners in the economy. The work to deliver a robust financial model will therefore need to be jointly produced by both commissioners and providers. Assumptions must be agreed and replaced/validated as more experience of the new models becomes available.
- 1.35 Commissioners and providers will need to understand the changes proposed within the new models, including the health and care interventions and, fundamentally, the financial impact upon the finite resources within Manchester in the longer term.

### **Investment Requirements**

- 1.36 The efficiency challenge is of such a magnitude that significant transitional, capital and revenue investment funds will be required to secure success, from any transformational funds secured by the Greater Manchester Devolution programme.
- 1.37 The complexities of the Manchester locality, comprising several distinct commissioners and providers, means that collaboration between partners will be essential to define the elements of investment funding needed to implement the programmes described in this plan.
- 1.38 Although financial modelling described above continues to develop, current estimates about the investment and phasing required to deliver benefits are incorporated within the bridge charts in Figures 1 and 2. Specific assumptions about transitional enabling costs are shown in Table 8 below.

<b>TABLE 8 – Transitional Costs</b>	<b>16/17</b>	<b>17/18</b>	<b>18/19</b>	<b>19/20</b>	<b>20/21</b>	<b>TOTAL</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>	<b>£m</b>
<b>Non-recurrent transitional revenue costs:</b>						
Double running costs					112.4	112.4
Support for Extra Care and LD Accommodation					2.8	2.8
Support redesign of hospital care	16.0	8.0	4.0			28.0
<b>Subtotal - Non-Recurrent Revenue</b>	<b>16.0</b>	<b>8.0</b>	<b>4.0</b>	<b>0.0</b>	<b>115.2</b>	<b>143.2</b>
<b>Capital (Note 1):</b>						
Capital - Extra Care Housing					36.3	36.3
Capital – Four new hubs (£4m each)		4.0	8.0	4.0		16.0
Capital – PAHT Crumpsall site		4.0				4.0
Capital – Refurbishment		2.0	6.0			8.0
Capital – Intermediate Care Beds	5.0	5.0				10.0
IT		1.0	3.0	2.0		6.0
<b>Subtotal - Capital</b>	<b>5.0</b>	<b>16.0</b>	<b>17.0</b>	<b>6.0</b>	<b>36.3</b>	<b>80.3</b>
<b>Total cash requirement</b>	<b>24.3</b>	<b>27.3</b>	<b>24.4</b>	<b>6</b>	<b>151.5</b>	<b>233.5</b>

- 1.39 Investment costs will be included within the CBA work for each strategy to ensure that only net benefits inform local considerations about the ‘value’ of investment decisions to Manchester. Positive CBA ratios – i.e. 1:1 or more – indicate a ‘return on investment’ (and vice versa) although decisions will not be taken necessarily entirely on the basis of this evidence.

### **Dependencies – Greater Manchester Transformation Plans and Wider System Work-streams**

- 1.40 Manchester’s success in meeting its efficiency targets is co-dependent upon the success of several Greater Manchester and/or wider sector and system transformation plans, including for example:
- Healthier Together for GM - implementation of single service models for Manchester
  - Provider reform, including expansion of single service care models and standardisation of clinical and back office services
  - GM wide plans, including mental health, primary/social care transformation, public service reform and public health programmes
  - GM enabling work streams e.g. estates, workforce and IM&T
- 1.41 At this stage, the impact of these plans is assumed to be within the other GM benefits in Table 5 above. Further development and financial modelling is

required however (at a Greater Manchester and/or wider system level, as well as locality) to provide further assurance about the deliverability of assumed savings.

### **Appendix 3 - Greater Manchester Population Health Outcomes - Quantifying the challenge for Manchester**

Over the next 5 years, based on current trends, there are projected to be:

- 35,858 children in Manchester achieving a good level of development by the time they start school. Matching Manchester's proposed share of the GM target would result in 36,852 children achieving a good level of development – equivalent to an additional 994 children in Manchester over the next 5 years (2016/17 to 2020/21);
- 1,375 babies born in Manchester with low birth weight. Matching Manchester's proposed share of the GM target would result in 1,298 babies born with low birth weight – equivalent to 76 fewer low birth weight babies in Manchester over the next 5 years (2017-2021);
- 168,110 children aged under 16 living in poverty in Manchester over the next 5 years. Matching Manchester's proposed share of the GM target would result in 163,593 children living in poverty – equivalent to 4,517 fewer children living in poverty over the next 5 years (2017-2021);
- 950 early deaths from preventable CVD in Manchester. Matching Manchester's proposed share of the GM target would result in 776 early deaths from preventable CVD – equivalent to 174 fewer deaths from preventable CVD over the next 5 years (2016-18 to 2020-22);
- 1,910 early deaths from cancer in Manchester. Matching Manchester's proposed share of the GM target would result in 1,532 early deaths from preventable cancer – equivalent to 378 fewer deaths from preventable cancer over the next 5 years (2016-18 to 2020-22);
- 703 early deaths from preventable respiratory diseases in Manchester. Matching Manchester's proposed share of the GM target would result in 535 early deaths from preventable respiratory diseases – equivalent to 168 fewer deaths from preventable respiratory diseases over the next 5 years (2016-18 to 2020-22);
- 5,986 hospital admissions due to falls in people aged 65 and over in Manchester. Matching Manchester's proposed share of the GM target would result in 5,333 hospital admissions due to falls in older people – equivalent to 653 fewer hospital admissions over the next 5 years (2016/17 to 2020/21)

In percentage terms, Manchester is closest to achieving its target share of the Greater Manchester aspiration for school readiness, low birth weight babies and children in poverty. These are all areas where trend data indicates that the city has been making good progress. Manchester is still some way off its target share of the Greater Manchester aspiration for the three mortality-based indicators and for hospital admissions due to falls in older people. In numerical terms, in order to achieve its target share of the Greater Manchester aspiration, the city would need to secure an additional 174 fewer deaths from preventable CVD, 378 fewer deaths from preventable cancer and 168 fewer deaths from preventable respiratory diseases over the next 5 years (2016-18 to 2020-22) compared with what is currently projected ('business as usual').

## Appendix 4 – Transformation Priorities: Logic Chains

<b>Transformation programme</b>	<b>Public Health – Children and Young People</b>
<b>Nature of problem</b>	Large numbers of children living in poverty with subsequent poor health outcomes or risk factors for poor health including lack of school readiness, obesity and accidental injuries.
<b>Proposed Solution</b>	Ensure public health commissioned services (health visiting, school nursing, family nurse partnership) are linked into the Early Help Hubs in order to provide health support in multiagency teams. To roll out the early years delivery model to all children in Manchester.
<b>Key Programmes</b>	Early Help Strategy Early Years Delivery Model
<b>Outputs</b>	Increase in number of: <ul style="list-style-type: none"> <li>Workers working across multiagency teams.</li> <li>Children and families helped to access universal services through targeted support.</li> <li>Early Help assessments carried out.</li> <li>Children identified for intervention pathways.</li> <li>Children and families accessing parenting skills courses.</li> </ul>
<b>Outcomes</b>	Increase in number of: <ul style="list-style-type: none"> <li>Children that are assessed as being school ready.</li> <li>Children experiencing co-ordinated, effective local offer.</li> <li>Children aged 0-19 years (25 for SEN) accessing early help and support.</li> </ul> <p>Significant and sustained progress for children, young people and their families. <i>Against what metrics?</i></p>
<b>Impact</b>	Narrow gap in key health and wellbeing outcomes for children. Improve emotional wellbeing of young children. Reduction in emergency hospital admissions for children. Reduction in accidents for children. Reduction in childhood obesity. More children aged 5 years achieve a good level of development that is at least in line with national average.

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<b>Transformation programme</b>	<b>Public Health – Adults of Working Age</b>
<b>Nature of problem</b>	High prevalence of mental ill health prevents individuals from getting back into, and sustaining work.
<b>Proposed Solution</b>	Embed fit for work programme as part of the scale up of GM health and work programme and build on incentives to encourage referrals from mental health services and primary care.
<b>Key Programmes</b>	GM health and work programme
<b>Outputs</b>	Increase in number of people engaged in health and work programmes in Manchester. Increase in number of people referred by GP practices and mental health providers into health and work programmes.
<b>Outcomes</b>	Increase in number of people referred into health and work programmes by GP practices and mental health providers who meet agreed programme outcomes <sup>1</sup> . Increase in appropriate referrals to health and work services by GP practices. Increase in people with mental health issues employed by HWBB member organisations.
<b>Impact</b>	Reduction in people claiming any ill-health related benefit. Reduction in adults suffering mood and anxiety disorders. Improved health and wellbeing status among people participating in health and work programmes.

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<sup>1</sup> Increased confidence levels in relation to obtaining employment; improvements in activation and self-care (incl. managing condition/symptoms, lifestyle, mental wellbeing); increased engagement in learning or skills activity and volunteering; securing and sustaining employment for 12 months.

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<b>Transformation programme</b>	<b>Public Health – Older People</b>
<b>Nature of problem</b>	High numbers of older people in Manchester are socially isolated and/or lonely with consequent impact on their mental and physical health and wellbeing.
<b>Proposed Solution</b>	Develop Age Friendly Neighbourhoods and teams and improve communication and engagement with older people.
<b>Key Programmes</b>	Age Friendly Manchester
<b>Outputs</b>	Increase in number of people aged 50-64 years in employment. Increase in number of older people engaged in Age Friendly Manchester networks.
<b>Outcomes</b>	Reduction in unemployment rate among people aged 50-64 years.

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Transformation Programme	Primary Care <sup>2</sup>
Nature of problem	<p>Existing model of primary care does not always work as a system of care, and could be more integrated, both within itself and in terms of how it links to other parts of the health and social care system.</p> <p>Responsibility for primary care commissioning is split across NHS England, CCGs and Public Health and national contracting arrangements restrict ability to innovate and develop local solutions.</p> <p>The primary care system is generally underfunded and fragmented resulting in a lack of resilience across the system. Federated models of provision are relatively underdeveloped and the existing workforce is under threat from impending retirements and ongoing difficulties in recruitment and retention.</p> <p>Existing estates and facilities provide a poor infrastructure and there are known variations in the quality of services provided and the standards of delivery.</p>
Proposed solution	<p>Continue to develop the new model of care, based around commissioning for population as well as more integrated provision of primary care as part of the LLLB/One Team strategy. Implement estates and workforce strategies to improve infrastructure.</p> <p>Deliver Enhanced Primary Care standards to address variation in quality of services provided.<sup>3</sup></p>
Key programmes	<p>Living Longer Living Better (LLLB)/One Team, Healthier Together Primary care 7 day access, Primary care standards<sup>1</sup></p>
Outputs	<p>Increase in number of:</p> <ul style="list-style-type: none"> <li>• GP practices offering extended opening hours.</li> <li>• Patients accessing primary care out of hours.</li> <li>• GP practices assessed against Enhanced Primary Care standards.</li> <li>• Patients receiving proactive care for long term conditions.</li> <li>• People referred by GP practices into health and work programmes.</li> <li>• GP practices routinely recording and reporting employment status of patients.</li> <li>• Primary care professionals working as part of an integrated team.</li> <li>• Lifestyle interventions delivered in primary care.</li> <li>• Patients signposted towards health and wellbeing and screening services.</li> </ul>

<sup>2</sup> Primary care here covering Medical care (GPs), Pharmacy, Dentistry and Optometry; although the initial focus is on primary medical care.

<sup>3</sup> Available at

<http://www.centralmanchesterccg.nhs.uk/download.cfm?doc=docm93ijjm4n2246.pdf&ver=2923>

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<b>Outcomes</b>	<p>Reduction in:</p> <ul style="list-style-type: none"><li>• A&amp;E attendances.</li><li>• Avoidable admissions to hospital.</li><li>• Number of delayed discharges.</li><li>• Length of stay.</li></ul> <p>Increase in the:</p> <ul style="list-style-type: none"><li>• Number of GP practices compliant with Enhanced Primary Care standards.</li><li>• Uptake of childhood vaccination and flu immunisation.</li><li>• Appropriate referrals to health and work services by GP practices.</li><li>• Number of people referred into health and work programmes by GP practices who meet agreed programme outcomes.</li><li>• Number of GP patients with a valid recorded employment status in primary care.</li><li>• Uptake of funded health and wellbeing and screening services.</li></ul>
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<b>Impact</b>	<p>Earlier identification of people at risk of ill health. More people accessing prevention, intervention and screening services and at earlier stages. Patients more engaged in managing their own conditions and self care. Improvements in the quality of care provided in primary care. More appropriate use of health care services. Better patient experience and expectations. Reduction in worklessness and improved productivity through reduction in ill health and absenteeism.</p>
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**Transformation programme (Living Longer Living Better – One Team)**

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**Nature of problem** The health and care system is focused on reactive care at the expense of prevention and early intervention. The delivery of health and social care is not sufficiently integrated and the workforce that provides it is fragmented and lacking in capacity and capability. This, combined with high levels of ill health in the population, has an impact on the quality and length of life for local people and draws resources away from more preventative approaches.

**Proposed Solution** Ensure that health and social care providers work as a more integrated system within the city and across GM as a whole, with a greater focus on prevention, early identification of ill health and more proactive, joined-up care through services delivered primarily in the community by a more confident workforce with appropriate skills and competencies in collaboration with voluntary and community sector providers.

**Key Programmes** Transformed Primary Care at scale  
Integrated intermediate care and reablement services  
Integrated Neighbourhood Teams

**Outputs** Increase in the number of:

- People having an agreed shared care plan.
- Patients receiving appropriate care through an integrated team.
- Health and care professionals working as part of an integrated team.
- People receiving a multi-disciplinary assessment using an appropriately validated tool.
- Patients appropriately referred to IC&R service.
- People appropriately discharged from IC&R service.
- Referrals dealt with within agreed response times.
- Appropriate people screened using frailty tool.
- Events or services delivered in partnership with voluntary and community sector providers.
- People reporting as 'self caring' in the city.

**Outcomes** Reduction in:

- Avoidable emergency hospital admissions.
- A&E attendances.
- Length of stay in hospital.
- Number of delayed discharges.
- Number of people able to live at home following discharge from IC&R.
- Permanent admissions to nursing care and residential care.
- Readmissions to hospital.
- Patient waiting times for non-urgent care (diagnostic tests

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etc.).

- Safety incidents linked to uncoordinated multidisciplinary working.

Improvement in level of independence based on validated frailty tool scores.

Increased amount of health and social care activity delivered in the community

Increase in staff satisfaction and reduction in staff turnover.

Increase in the number of people supported to die in their place of choice.

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**Impact**

Reduction in:

- Mortality from causes considered amenable to healthcare.
- Spend on acute hospital care.
- Residential/nursing provision.

Increase in:

- Health-related quality of life for people with long term conditions (LTCs) and their carers.
- People feeling independent and able to manage their LTCs in their own homes.
- Proportion of spend on services delivered in the community.
- Participation of patients, carers, family and local people in the care assessment and planning process.
- Effectiveness satisfaction of the workforce.

Improvement in patient and carer experience of community-based services.

Improvement in quality and safety of community-based services.

Improved experience of palliative/end of life care.

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<b>Transformation programme</b>	<b>Living Longer Living Better – Urgent Care First Response<sup>4</sup></b>
<b>Nature of problem</b>	The urgent care system is characterised by duplication, overlap and high use of expensive care. There have been numerous initiatives over the years seeking the dual “holy grails” of reducing non elective admissions and A&E attendances.
<b>Proposed Solution</b>	Develop a new model of urgent carer to ensure that the system is simple for patients and referrers to navigate, remove duplication and overlap and reduce the use of high cost reactive services.
<b>Key Programmes</b>	Living Longer Living Better (LLLB)/One Team
<b>Outputs</b>	Increase in number of people treated in line with commonly agreed standards for urgent care. Increase in the number of patients whose care is managed over the telephone. Increase in the number of patients accessing urgent primary care. All Manchester urgent care services and pathways are included in 111 directory of service.
<b>Outcomes</b>	Reduction in serious and untoward errors in urgent care. Reduction in non-elective admissions and other high cost interventions. Reduction in healthcare acquired infections (HCAI). Reduction in A&E attendances.
<b>Impact</b>	More efficient commissioning and provision of urgent care services. Improved patient and referrer satisfaction. Increase in people in control of their own condition. Increased self reliance. Reduction in disability and mortality from causes considered amenable to healthcare. Improved equity of access for people with protected characteristics and other groups. Reduction in overall cost of urgent care. Reduction in duplication of urgent care services.

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<sup>4</sup> Urgent Care First Response (UCFR) is the urgent care component of One Team

<b>Transformation programme</b>	<b>Living Longer Living Better – Dementia Care</b>
<b>Nature of problem</b>	The number of people with dementia in Manchester is increasing but specialist service provision in Manchester varies across the city and some 'general' services are not geared up to cater for people with dementia. Diagnosis rates vary across the city as does the level of post diagnosis support and support for carers.
<b>Proposed Solution</b>	<p>Refresh the Dementia Strategy for Manchester.</p> <p>Redesign Later Life and Dementia services to reintroduce Dementia Support Advisor roles.</p> <p>Work with the Alzheimer's Society to map dementia services and improve access and awareness. (Dementia Journey Roadmap)</p> <p>Roll out Dementia Friends training to all GP practices and social care assessors.</p> <p>Review medicines management and prescribing to ensure appropriate use of anti-psychotic drugs.</p> <p>Carry out cost benefit analysis on MHIP dementia care pathway to inform gaps in provision.</p> <p>Develop a performance management template for dementia services across MCC and CCG commissioned services.</p> <p>Further expand GP clinical advice line to the Acute Trust.</p>
<b>Key Programmes</b>	Living Longer Living Better/One Team Age Friendly Manchester
<b>Outputs</b>	<p>Increase in the number of:</p> <ul style="list-style-type: none"> <li>• patients screened for dementia by GP practices.</li> <li>• people from BME communities screened for dementia by GP practices.</li> <li>• patients seen by primary, community, voluntary and specialist services.</li> <li>• Health Care Professionals working in the community.</li> <li>• Dementia Advisors working as part of the Dementia Community Service.</li> <li>• patients being prescribed anti-psychotic medications receiving a medicines review.</li> <li>• staff performing health and social care duties attending dementia awareness training.</li> </ul>
<b>Outcomes</b>	<p>Increase in the:</p> <ul style="list-style-type: none"> <li>• number of people receiving a timely diagnosis of dementia.</li> <li>• dementia diagnosis rate among BME communities.</li> <li>• number of carers accessing local voluntary and community groups</li> <li>• number of staff equipped with the skills to support people with dementia effectively.</li> </ul> <p>Reduction in the:</p> <ul style="list-style-type: none"> <li>• waiting time from referral to diagnosis.</li> <li>• number of avoidable hospital admissions among people with dementia.</li> </ul>

- number of avoidable residential care placements among people with dementia.
  - length of stay in hospital for people with dementia.
  - number of patients with dementia being prescribed inappropriate anti-psychotic medications.
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**Impact**

Improved access to treatment, support and services.  
Improved access to dementia services for BME communities.  
Reduced variation in dementia diagnosis between GP practices.  
Improved health and wellbeing of people with dementia and their carers enabling them to self care and maintain the carer relationship.  
More people able to continue living in the community supported by appropriate services.  
Fewer people reaching crisis point such that they need for secondary/ residential care services.  
Improved patient/carer experience of dementia care.  
More patients with dementia receiving appropriate medication.  
Reduced spend on residential and hospital care for people with dementia.  
Improved quality of health and social care delivery for people with dementia by appropriately trained staff.

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<b>Cancer Care across Manchester</b>	
<b>Transformation programme</b>	
<b>Nature of problem</b>	Unhealthy lifestyles, low screening uptake and late stage at diagnosis contribute to high premature mortality from cancer. Improved survival meaning more people living with and beyond their cancer diagnosis, living with consequences of their cancer and side effects of treatment requiring surveillance and monitoring Cancer now considered a long term condition
<b>Proposed Solution</b>	Increased emphasis on prevention and early detection of cancer, alongside the development of new models of aftercare and palliative/end of life care.
<b>Key Programmes</b>	Manchester Macmillan Cancer Improvement Partnership Programme National ACE programme (NHSE, Macmillan & CRUK) – Wave 1 and 2 Living Longer Living Better (LLLB) / One Team
<b>Outputs</b>	Increase in number of people attending health and wellbeing events and physical activity programmes Increase in number of eligible patients attending cancer screening appointments Reduction in number of eligible patients not attending cancer screening appointments Increase in number of patients with written care plans Increased in number of patients on a stratified care pathway Increase in number of patients receiving targeted investigations for early identification of risk of lung cancer Increase in numbers of cancer champions in primary care and community services Increase in number of patients seen as part of MCIP project
<b>Outcomes</b>	Increased awareness of impact of healthy lifestyles and smoking cessation on cancer Increase in screening uptake rate Increase in proportion of cancers diagnosed at an early stage (especially lung and bowel cancers) Reduction in number of routine hospital based follow up appointments Increase in number of cancer patients receiving palliative and end of life care
<b>Impact</b>	Improved survival from cancer Improved support for patients post diagnosis Reduce premature mortality from cancer Improved health related quality of life for patients with cancer / long term conditions Improved patient and care experience of end of life care More patients empowered to self-manage their recovery and seek

advice for new symptoms or problems  
More efficient use of diagnostic resources and time to diagnosis  
improved

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**Mental Health Improvement Programme: Common mental health problem pathway**

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<b>Nature of problem</b>	<p>Need to develop a robust community offer through the work of LLLB and One Team</p> <p>There is a need to reduce Fragmentation of providers across the city, which can result in difficulty for patients in easily accessing the right help.</p> <p>Long waiting lists in some services and thus limited access in a timely way can impact on the patients journey outcome and experiences</p> <p>there is a need to ensure that services deliver improved outcomes for people – that they recover and have an improved quality of life.</p> <p>Care offered and majority of investment sits with reactive care and intensive provision, investment needs to be realigned to proactive care – evidence based care and early intervention. Re distribution of resources required, though this will only be enabled if acute and rehabilitation care pathways are effective and if early intervention is resourced</p>
<b>Proposed Solution</b>	Development and implementation of common mental health problem pathway (one of 17 proposed MHIP care pathways).
<b>Key Programmes</b>	<p>MMHSCT transaction process (TDA led)</p> <p>GM Devolution programme (for acute and hospital care)</p> <p>Living Longer, Living Better (LLLB)/One Team (for community provision)</p> <p>IAPT</p> <p>Integrated service offer from all CCG commissioned third sector</p>
<b>Outputs</b>	<p>Increase in:</p> <ul style="list-style-type: none"> <li>• spend on psychological therapies required.</li> <li>• the number of psychological therapy interventions available for different levels of severity.</li> <li>• the number of people assessed and referred to an appropriate intervention.</li> <li>• the number of referrals to IAPT entering treatment.</li> <li>• the number of people accessing psychological therapies who are also in receipt of an employment support package.</li> <li>• the number of people entering therapy who have waited less than 18 weeks.</li> <li>• the number (and %) of people referred to IAPT finishing a course of treatment.</li> <li>• the number of patients treated in line with an appropriate PbR tariff.</li> <li>• the number of people seen as part of One Team model referred to appropriate psychological and MH interventions.</li> </ul> <p>Expected number of people entering psychological therapy</p>

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	<p>completing therapy. Average number of contacts by people in receipt of psychological therapies. Reduction in number of people dropping out of treatment.</p>
<b>Outcomes</b>	<p>Increase in the proportion of referrals to IAPT that moved to recovery at the end of treatment. Reduction in re-referrals to psych therapies. Reduction in hospital admission/readmissions. Increase in people offered least intensive but effective intervention. Increase in proportion of people with common mental health disorders in employment. Increased utilisation of full service capacity (e.g. reduction in vacant posts).</p>
<b>Impact</b>	<p>Reduced spend on intensive (Step 4) interventions (inpatients and community). Improved quality of life among people with common mental health problems and their families. Increase in people with common mental health problems in stable employment. Increase in number of people with common mental health problems treated in the community. Reduction in time spent in hospital by people with a common mental health problem. Improved patient, carer and family experience of community mental health services Increased value for money.</p>

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<b>Transformation programme</b>	<b>Mental Health Improvement Programme: First episode of psychosis pathway</b>
<b>Nature of problem</b>	As described in Common mental health problem pathway above
<b>Proposed Solution</b>	Development and implementation of first episode of psychosis pathway (one of 17 proposed MHIP care pathways).
<b>Key Programmes</b>	Development of service offer to meet new standard – MMHSCT and RDASH One team
<b>Outputs</b>	Increase in number of people experiencing a first episode of: <ul style="list-style-type: none"> <li>• psychosis entering the MHIP pathway.</li> <li>• psychosis accessing EIP service with MCC commissioned employment support services.</li> <li>• psychosis accessing physical health screening and treatment services (primary care/neighbourhood teams).</li> <li>• psychosis accessing CBT in line with standard.</li> <li>• psychosis accessing family interventions in line with standard.</li> <li>• psychosis accessing well-being interventions such as smoking cessation and physical exercise.</li> </ul>
<b>Outcomes</b>	Increase in: <ul style="list-style-type: none"> <li>• people recovering from a first episode of psychosis showing a reduction in symptoms.</li> <li>• people offered least intensive but effective intervention.</li> <li>• people with a first episode psychosis treated with a NICE approved care package within two weeks.</li> <li>• proportion of adults in contact with secondary care MH services in paid employment.</li> <li>• proportion of adults in contact with secondary mental health services living in stable and appropriate accommodation.</li> <li>• average health status score on assessment and on discharge (based on EQ-5D score).</li> <li>• people with MH illness feeling supported to manage their condition.</li> </ul> <p>Reduction in people experiencing an escalation of need and crisis requiring MH inpatient care or crisis community care. Reduction in mental health readmissions within 30 days. Reduction in smoking status among people experiencing a first episode of psychosis. Reduction in obesity among people experiencing a first episode of psychosis.</p>

**Impact**

Reduction in excess premature (<75) mortality rate for people experiencing a first episode of psychosis in contact with mental health services.  
Improved physical health of people experiencing a first episode of psychosis.  
Improved quality of life for people experiencing a first episode of psychosis.  
Improved patient, carer and family experience of mental health services.  
Reduced spend on out of area treatment.  
Increased value for money.

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<b>Transformation programme</b>	<b>Mental Health Improvement Programme: Integrated community rehabilitation from psychosis pathway</b>
<b>Nature of problem</b>	As described in Common mental health problem pathway above
<b>Proposed Solution</b>	Development and implementation of integrated community rehab from psychosis pathway (one of 17 proposed MHIP care pathways).
<b>Key Programmes</b>	MH QIPP programme
<b>Outputs</b>	Number of people receiving an appropriate clinical assessment in acute and rehabilitation wards.
<b>Outcomes</b>	<p>Increase in number of patients in an out of area placement returning to local services.</p> <p>Reduction in LOS in out of area placements.</p> <p>Increase in average health status score on assessment and on discharge (based on EQ-5D score).</p> <p>Reduction in smoking status among people experiencing an episode of psychosis.</p> <p>Reduction in obesity among people experiencing an episode of psychosis.</p>
<b>Impact</b>	<p>Improved physical health of people experiencing an episode of psychosis.</p> <p>Improved quality of life for people experiencing an episode of psychosis.</p> <p>Improved patient, carer and family experience of mental health rehabilitation services.</p> <p>Reduced spend on out of area placements.</p> <p>Increased value for money of community rehabilitation services.</p>

<b>Transformation programme</b>	<b>Mental Health Improvement Programme: Acute mental health care pathway</b>
<b>Nature of problem</b>	As described in Common mental health problem pathway above
<b>Proposed Solution</b>	Development and implementation of acute mental health care pathway (one of 17 proposed MHIP care pathways). Increase investment in development of acute care and community home treatment care.
<b>Key Programmes</b>	Risk share in MMHSCT National programme for MH liaison services in acute hospitals TDA sustainability process Greater Manchester Devolution programme
<b>Outputs</b>	Number of people with an acute or serious episode of mental illness receiving a clear intervention offer based on evidence based treatment. Increase in number of people with an acute or serious episode of mental illness receiving an effective discharge plan.
<b>Outcomes</b>	Reduction in: <ul style="list-style-type: none"> <li>• the number of out of area acute care placements for patients with an acute or serious episode of mental illness.</li> <li>• average length of stay for people with an acute or serious episode of mental illness.</li> <li>• delayed transfers of care within acute wards and community home treatment teams for people with an acute or serious episode of mental illness.</li> <li>• acute hospital readmissions within 30 days for people with an acute or serious episode of mental illness.</li> <li>• the number of mixed Sex Accommodation (MSA) Breaches.</li> <li>• the number of people with an acute or serious episode of mental illness experiencing a 12 hour wait in A&amp;E for admission.</li> </ul> <p>Increase in number of for people with an acute or serious episode of mental illness discharged to their own homes. Increase in number of people with an acute or serious episode of mental illness receiving a Care Programme Approach (CPA) 7 day follow-up. Increase in number of for people with an acute or serious episode of mental illness reporting improved outcomes (PROMs).</p>

**Impact**

Reduction in mortality from suicide and undetermined injury.  
Safer and more effective management of acute and serious episodes of mental illness.  
Improved physical health of people with a severe mental illness.  
Increase in people with a severe mental illness feeling supported to manage their condition in their own home.  
Improved quality of life for people with a severe mental illness.  
Improved patient, carer and family experience of acute mental health care.  
Reduced spend on private, out of area, acute and rehabilitation beds.  
Increased value for money of acute mental health care.

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<b>Transformation programme</b>	<b>Children and Families: Looked After Children</b>
<b>Nature of problem</b>	<p>High volume of LAC compared to comparators and core cities leading to high overall spend. NB Cost per LAC is average. Increasing flow of LAC (nationally and in Manchester but LAC population always volatile). Historically social work culture does not fit with focus on reduction in LAC (perceptions of risk). Historically partners too easily treat MCC as 'parent of last report'. Cannot reduce costs through reducing social workers.</p>
<b>Proposed Solution</b>	<p>CD work will reduce LAC flow. Better targeted interventions for 0-5s and 15-17s. Greater focus on: adoption; re-balancing from residential to foster care, placements in the City; decommissioning internal residential provision; work and skills; work with extended families. Focus on progression and exit through targets for reduction, emphasis on permanent outcomes, tracking outcomes. Strengthened performance management. Workforce development of social workers. Social worker caseloads reduced. Collaboration and co-commissioning of care services.</p>
<b>Key Programmes</b>	<p>Multi-agency LAC partnership group. Digital working strategy.</p>
<b>Outputs</b>	<p>Increased rates of adoption. Increased rates of fostering. More care leavers with skills. More care leavers in decent work. Good flow of performance management information. Changed attitudes of social workers to LAC reductions. Reduced social worker caseloads. Cost-effective care services in place. Plans with partners in place. Digital working strategy in place.</p>
<b>Outcomes</b>	<p>Reduced flow of LAC. Reduced rate of LAC admission. Reduced stock of LAC. Increased rate of LAC discharge. Reduced duration in care. Better outcomes for LAC and other children with potential to become LAC.</p>
<b>Impact</b>	<p>Residents more independent, resilient, school ready and economically active.</p>

<b>Transformation programme</b>	<b>Children and Families: Safeguarding</b>
<b>Nature of problem</b>	<p>Ofsted report of 1 September 2014 judged children's services as inadequate e.g.: children waiting a long time for social work assessment; quality assurance and management oversight not robust; high social work caseloads; poor partner understanding of thresholds; poor engagement in early help; too many children waiting for adoption; ineffective challenge of poor practice. Manchester's child population has grown by 2% (av.) over past decade. 37% live in poverty.</p>
<b>Proposed Solution</b>	<p>Review caseloads. Ensure correct staffing levels. Ensure robust management oversight. Improve collation, accuracy and reporting of performance data. Effective targeting and coordination of early help: scale up Troubled Families approach e.g. specialist CiN team, lead workers, Local Integration Team, triage, MASH, Public Service Hub. Prioritise the recruitment of adopters. Increased use of voluntary adoption agencies. Accelerate foster to adopt. Act on children's feedback – improve effectiveness of independent reviewing officer service.</p>
<b>Key Programmes</b>	<p>Children's Improvement Plan</p>
<b>Outputs</b>	<p>Manageable caseload levels. Timely assessments. Proper attendance at meetings/case conferences etc. Proper record-keeping. More accurate, timely information available. Better understanding of when to refer/offer other support. More appropriate interventions. More and more variety of adopters.</p>
<b>Outcomes</b>	<p>Improved safeguarding. Reduced referrals. More families in employment. Reduced mismatch of adopters and children. Quicker adoptions.</p>
<b>Impact</b>	<p>Reduced proportion of Manchester's children are in need i.e. reduced dependency.</p>

<b>Transformation programme</b>	<b>Children and Families: Complex Dependency</b>
<b>Nature of problem</b>	Worklessness in Manchester above core city and national average. Higher than average number of residents with low skills levels. Higher than average number of LAC. High number of residents using targeted services.
<b>Proposed Solution</b>	Scaling up Troubled Families including those at risk of becoming complex. Sharper focus on employment as key route out of 'complexity'. Effective cohort analysis and neighbourhood intelligence. Controlling entry through integrated front door, MAPSH. Multi-agency assessment and case allocation. Coherent early help e.g. Early Help Coordinators. Tier 1 key workers – bespoke plan (family based approach). Tier 2 draw down specialist support. Prioritising cases e.g. 0-5, return to home, 15-17. Support for integrating services through Local Integration Teams. Negotiating with partners to elicit resources for new delivery model. Workforce development. Address ICT challenges.
<b>Key Programmes</b>	Troubled Families Programme Confident and Achieving Manchester Programme
<b>Outputs</b>	More accurate identifications of Troubled Families by MCC and partners. Greater uptake of Early Help offers. More key workers, including staff from partner organisations. Wider range of flexible Tier 2 services available.
<b>Outcomes</b>	Reduced stock of Troubled Families. Reduced flow of Troubled Families. Fewer workless households. Fewer ESA/IB claimants. Fewer working Tax Credit claimants. Lower youth offending. Improved skills levels. Fewer mental health service users. Reduced flow of LAC. Improved school readiness and attendance.
<b>Impact</b>	Residents more independent, resilient, school ready and economically active.

<b>Transformation programme</b>	<b>Housing and Assistive Living Technology</b>
<b>Nature of problem</b>	The type, volume and quality of accommodation in the city does not support independent living and results in too many residents moving to residential care. Excess admissions to A & E from residential and nursing homes when residents are unwell.
<b>Proposed Solution</b>	<p>Ensure that accessible housing and financial advice and guidance is available for older people, carers and health and care professionals.</p> <p>Develop additional extra care housing units and re-commission sheltered schemes as extra care lite.</p> <p>Develop additional supported living schemes for learning disabled residents.</p> <p>Scale up provision of Assistive Living Technology to reduce hands on social and health care costs.</p> <p>Increase use of telemedicine to manage long term conditions more effectively in the community and deal with medical scenarios onsite within the home.</p> <p>Develop a social care cluster of equipment and related services to ensure consistent access to equipment and adaptations.</p> <p>Develop a more streamlined rehousing offer making best use of the city's adapted housing stock.</p> <p>Targeted reduction in use of residential and nursing care when alternative options are available.</p>
<b>Key Programmes</b>	<p>Living Homes</p> <p>Housing for an Age Friendly Manchester Residential Growth Programme</p> <p>Care Closer to Home</p> <p>Winterbourne Resettlement Programme</p> <p>LLLLB</p> <p>All Age Disability Strategy</p>
<b>Outputs</b>	<p>Increase in number of older people and their carers accessing HOOP (Housing Options for Older People) and web based advice services.</p> <p>Increase number of Extra Care housing units providing long term independent living with care on-site.</p> <p>Step up step down units within extra care schemes.</p> <p>Increase in number of additional units of supported accommodation for people with LD.</p> <p>Increase in number of units of replacement accommodation.</p> <p>Increased usage of ALT equipment across health and care services.</p> <p>Increase in proportion of equipment and adaptation that is recycled.</p>
<b>Outcomes</b>	<p>More older people understand housing options for later life and move to appropriate accommodation in a timely manner.</p> <p>Reduction in admissions to residential and care homes.</p>

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Reduction in falls and emergency hospital admissions.  
Reduction in number of care hours required.  
Best use made of adapted homes.  
Reduction in waiting times for equipment and adaptations.  
Improved co-ordination of re-let of specialist housing stock.  
Reduction in NWS calls.  
Reduction in A & E attendances among care home residents.

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**Impact**

Reduction in expenditure on residential care.  
Reduction in expenditure in health services.  
Release of large family homes to support economic growth.  
Improved health and wellbeing and quality of life.  
Sustained independence.  
Reduction in social isolation.  
More cost effective delivery of services.

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<b>Transformation programme</b>	<b>Learning Disability</b>
<b>Nature of problem</b>	Recognition that the current configuration of care pathways across Manchester is disparate and fragmented. This does not match the national requirements or the aspirations for Manchester set out in the Locality Plan.
<b>Proposed Solution</b>	Develop more coordinated and sequenced care pathways for people with learning disabilities across health and social care in Manchester based on the national specification and service model.
<b>Key Programmes</b>	Living Longer, Living Better/One Team GM LD Fast Track Programme Transforming Care for People with Learning Disabilities, Next Steps
<b>Outputs</b>	Increase in number of Manchester patients repatriated from healthcare facilities in line GM LD Fast Track Targets (25 people). Increase in number of people with learning disabilities on a coherent, coordinated and fully integrated Care Pathway. Increase in number of people with learning disabilities receiving an annual health screening. Increase in number of people with learning disabilities referred onwards to mainstream services for support. Increase in number of people with learning disabilities on a pathway to access employment, skills and training.
<b>Outcomes</b>	Reduction in the number of people who require specialist inpatient admissions. Reduction in number of crisis/avoidable emergency hospital admissions among people with learning disabilities. Reduction in length of stay in hospital among people with learning disabilities. Reduction in number of delayed discharges among people with learning disabilities. Reduction in readmissions to hospital among people with learning disabilities. Increase in the number of people supported to live independently in the community and stepped down into good quality provision. Increase in the number of people in employment and actively accessing skills and training opportunities.
<b>Impact</b>	Improved health and quality of life for people with learning disabilities and their carers. Increased participation of people with learning disabilities and their carers in the planning and design of health and care

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services.

Improved quality of provision for patients with learning disabilities and their carers.

Increased independence for patients with learning disabilities and their carers within community settings.

Improvements in ability of workforce across mainstream provision to respond to people with learning disabilities.

Improved availability of specialist clinical support for patients with learning disabilities and their carers.

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