NHS
Greater Manchester

NHS GREATER MANCHESTER BOARD MEETING
AGENDA ITEM NO 5

Date of Board meeting: 25th March 2013

REPORT OF:	Leila Williams, Director of Service Transformation, NHS Greater Manchester
DATE OF PAPER:	**25th March 2013**
SUBJECT:	Healthier Together: Strategic Direction Case
IN CASE OF QUERY, PLEASE CONTACT	Leila Williams, Director of Service Transformation, NHS Greater Manchester leila.williams1@nhs.net

PURPOSE OF PAPER:
The Healthier Together programme is part of a wider review of Health and Social care in Greater Manchester aimed at saving and improving thousands of lives every year. Our Vision is "For Greater Manchester to have the best health and care in the country".

This paper will:

- Recap the goals and objectives of the programme which will result in a recommendation on the future shape of health and social care services in Greater Manchester. This will lead to a public consultation exercise on the proposals which will be undertaken collectively, on behalf of the wider system, by local Clinical Commissioning Groups;
- Provide an overview of the process required to complete the programme and undertake a successful public consultation exercise, highlighting the progress made against key milestones;
- Summarise new governance arrangements that are being put into place to reflect the implementation of new NHS commissioning arrangements from 1st April 2013;
- Highlight the need to deliver at scale and pace the enhancement of 'integrated care' and 'out of hospital' services, self-care and improved primary, community and social care services across the Greater Manchester wider system, as part of a fundamental shift in the way existing services are commissioned and how people access services;
- Provide a summary of the work undertaken to date on proposed future hospital based models of care – led by clinicians and informed by the public as part of a pre-consultation exercise – which respond to the previously agreed clinical cases for change and which have been developed to support a viable, safe and sustainable health and social care system;
- This work includes an outline of the potential 'types' of hospital that could support these models of care, providing an illustration of the building blocks for the future development of options for future hospital configuration;
- Outline the financial case in support of system-wide service reconfiguration as the only way to achieve a safe and sustainable way of delivering health and care services in Greater Manchester; and
- Recommend a set of 'next steps' that support the process required to deliver a future successful consultation on how services could be delivered to improve care and that builds on the momentum created in our communities for change.

Board is asked to:

- recognise that Healthier Together is a major legacy for the Board of NHS Greater Manchester;
- approve the document and commend it to CCGs;
- recommend that the work from April 2013 continues in the same vein, namely with clear robust governance arrangements, detailed involvement of clinicians and open & transparent engagement with the public;
- recommend that commissioners formally share the outline clinical model with providers for their response; and
- anticipate that public consultation will be required for any proposal that will come forward as a result of the work later in 2013.

Contents

Executive Summary

Background

The Healthier Together programme is one element of a wider public service system reform agenda seeking to improve outcomes for all Greater Manchester residents. It aims to save and improve thousands of lives each year.

It is set in the context of Health and Care service reform across Greater Manchester and a shared ambition of delivering better outcomes for Greater Manchester residents and patients at a lower cost; for people to remain independent and in control of their lives; and for better quality outcomes (survival and recovery rates) from hospital services.

Greater Manchester is constantly evolving with growing and vibrant communities, and on average local people are living longer than ever before. This is good news, but it puts severe pressure on our health system, much of which was designed for the needs of the last century.

There is a common understanding across the health and social care system that we need new service models to keep people who do not need hospital services closer to their own homes and communities. At the same time we know for those people who do need hospital services, care is variable. Not all of our hospitals meet best practice standards and guidelines because too many attempt to do everything. This is not acceptable in terms of quality and safety standards, nor is it affordable or an effective use of public money. If we do not act decisively now, some services, and possibly entire hospitals will fail.

As such Health and Social Care leaders support the development and implementation of 10/12 new locally derived models of integrated care and more accessible services, in parallel with the need to reconfigure hospital services. This will significantly reduce avoidable and unplanned admissions to hospital and other care institutions; whilst recognising that for some hospital services, a Greater Manchester wide planning perspective is needed.

This document is the basis for further discussion with all partners.

Progress

Extensive work has taken place on the Healthier Together programme under the leadership of NHS Greater Manchester board. Over the last 18 months, discussions with clinicians and other partners have shaped our proposals. Health is everyone's business and so our list of stakeholders is extensive, and includes patients and the public; staff and clinicians; and a wide range of partner organisations including local authorities, the third sector, trade union groups, the business community and the media. Further information is provided in section 3.

Over this time, over twenty special clinical congresses involving hundreds of clinicians have considered the issues facing our health system. They have explored the potential solutions to ensure that services remain high quality, safe and cost effective for future generations. This work which has been based on evidence and best practice from around the world has been developed into an overarching clinical case for change, providing an overview of the Greater Manchester health and care economy and clearly identifying strategic areas where change is needed.

A number of work streams focussing on these strategic areas have been progressed by the clinical congresses, where informed discussions about the future for these services have been held and where individual sets of standards and models of care have been developed.

The Greater Manchester Outline Model of Care

The outline model of care is based on partnership working between health and social care professionals across Greater Manchester; the development of "Integrated Care" services; and radically improved ways of working in secondary care, designed to provide enhanced levels of specialist, senior medical and nursing staffing. All of these elements would combine to provide the right services, at the right place, at the right time for individual patients, giving everyone the best possible chance of survival and recovery whilst keeping and treating them as close to where they live as possible.

The outline model of care will be developed and enhanced as further work and discussion takes place with the public, patients and clinicians.

Delivering Integrated Care across Greater Manchester

It has been widely recognised that in order to deliver better quality, targeted and more responsive local services that achieves a substantial reduction in avoidable admissions to hospital and other care institutions, we need a significant shift in the way care is organised, delivered and accessed across the whole system. Stakeholders across Greater Manchester have developed a framework to capture the key principles underpinning this.

The Association of Greater Manchester Authorities (AGMA) Executive has challenged all partners to work together to deliver new models of integrated or "joined up" care. A significant amount of work has already started across Greater Manchester, demonstrating new ways of commissioning and providing integrated care through new service delivery models. The planning and delivery of these initiatives will continue to be determined locally. However a significant challenge for Greater Manchester is ensuring that, collectively, local integrated care models operate at the appropriate scale and pace to deliver maximum benefit to patient/user results (outcomes) and the increased capacity in the community to support the changes required to achieve an effective and financially sustainable care system.

Section 4.1 sets out the suggested components and settings for Integrated Care, recognising that although each local partnership will define its own Integrated Care model that there will be commonalities across them all.

Key to the delivery of Integrated Care is the role played by Primary Medical Care. The primary care clinical congress has agreed a vision for this service and a high-level "ten point plan" has been developed to enable systematic and wide scale change. This includes increased access to primary care which remains a high priority with patients. Further information is provided in Section 4.2.

Delivering safe and sustainable secondary care services

It is recognised that a new model of care is required in a number of key clinical areas and this will change the nature of our hospitals across Greater Manchester. The building blocks that will contribute to the development of future services are outlined in Figure 5. They have been developed alongside clinical standards which will reinforce the requirement for services to provide the same high standards during the day, night and weekend in Greater Manchester.

A key component of this is the creation of a **single service** which will link all hospital sites and ensure patients are cared for in a joined up way, with professionals providing services at different locations based upon patient needs. The combination of the three different types of hospitals proposed, recognises the different needs across Greater Manchester.

The importance of an effective emergency service cannot be underestimated as an increasingly ageing population is balanced with rapid developments in the care of acutely unwell patients. The Healthier Together programme proposes that the outline model of care for urgent, emergency and acute medicine is built on the premises that a **single service** for each area will reduce the duplication, confusion and inefficiency in the services. Each local **single service** would be designed to match local needs; it is proposed that a number of acute services could be commissioned in a unified way as a **single service.**

A key principle of the **single service** is the connection of all elements of the service to make sure every patient has access to the "Right Care at the Right Place at the Right Time".

The Financial Picture
Making the best use of healthcare resources is essential if we are to achieve our vision.

Health and care services are under unprecedented financial pressure, and we know that this will increase in coming years. If we do not act now the system will become steadily less sustainable and some of our services, and probably entire hospitals, will fail.

Examples of the severe financial challenges faced by healthcare commissioners and providers, Clinical Commissioning Groups and Local Authorities are:

- Increased demand for services, due to an ageing population, higher patient expectations, better technology, unnecessary use of A&E and other services by patients and increased referral rates from primary care;
- Limited increases or real reductions in funding over the next few years;
- Cost inflation; and
- Reduction in tariff.

Work has taken place at an individual CCG and provider level to address this with some success, but a collaborative approach is needed to deliver the step change needed to ensure that we continue to provide safe and effective services. Further savings need to be made in non-front line costs such as rationalised estates; reduced management costs and improved operational efficiency.

There will be some financial considerations around the transition, including the need for some capital investment in estates where needed and the release of estates where they are not fit for purpose as well as double running costs as we seamlessly switch from old to new ways of working. Some pump priming will be needed to make this happen, but this will be offset by the longer term financial savings.

The Greater Manchester health economy cannot be made financially viable without organised system wide change. All parts of the system rely upon one another to function effectively and can no longer achieve financial balance and meet increased quality standards by acting in isolation. It is our responsibility to ensure that the people who live here are aware of this and have the opportunity to shape the solutions rather than sitting back and allowing individual providers to fail.

Management & Implementation
From April 2013, both the Association of Greater Manchester CCGs and the National Commissioning Board Area Team will have responsibilities and accountabilities in ensuring the successful delivery of the programme. A leadership mechanism has been put in place to enable this, which also recognises the importance of placing the programme within the context of wider health and social care reform.

There is a thorough process for developing the outline model of care and for taking this through to options on which the public will be consulted.

New regulations for public consultation come into force in April 2013, but the underlying obligation remains to operate a Full, Fair and Honest consultation. We want to ensure that a maximum number of affected people are aware of the consultation, the reasons behind it, have the opportunity to respond to it and for their responses to inform the outcome. We will be using a model of Campaign, Outreach, Response and Evaluation to help us achieve this.

Next steps and timescales

Although much progress has been made, it is clear there is a significant amount of work to do to accelerate the further development of a Greater Manchester-wide view of integrated care across health and social care partners that supports and aligns to Local Integrated Care models. Immediate next steps will include engagement regarding the on-going co-design of a framework of integrated care and developing an understanding of local integrated plans and their possible impacts on acute activity reductions; continued engagement with the Primary Care Clinical Congress and Summit; and a review of the primary care estate.

Clinical standards for some in-hospital care services have already been developed and agreed but commissioners now need to decide whether additional standards are needed for other specialities as recommended by the Clinical Reference Group. This will be considered by the new Healthier Together decision making structure in April, and it is envisaged that any such work would be completed by June 2013, after which the new in-hospital models of care can be stress tested and the development of the options for future hospital reconfiguration be completed.

Subject to the completion of all the necessary process steps outlined within this paper, our aim is to go out to public consultation on the future shape of health and care services in Greater Manchester later in 2013 .

Conclusion

The NHS in Greater Manchester has served the public well for over 65 years, but we recognise that we are no longer meeting the needs of our patients, and they deserve better. We are committed to working with all our stakeholders and partners to achieve the kind of transformational change needed to give everyone the excellent, compassionate care they would want for themselves and their families.

1 Introduction

1.1.1 The Healthier Together Programme is one element of a wider public service system reform agenda seeking to improve outcomes for all Greater Manchester residents. We believe that the people who live here deserve the best possible care. Our evidence shows that the only way to achieve this within the realities of the budgets available to us is to take a new approach to the way that care is organised, delivered and accessed across the whole system. This means changing the way we do things in community and primary care (out of hospital) as well as in hospitals (secondary/acute care), as well as reviewing the way that health and social care services interact.

1.1.2 The NHS in Greater Manchester has an excellent track record of delivering transformational projects. The programme builds upon recent successful changes to hospital services including women's and children's, stroke, cancer and major trauma services. These have consolidated excellent services and redesigned patient pathways (the ways in which patients progress through the system), to improve patient survival and recovery rates or "outcomes". This has already saved hundreds of lives, and we know that if delivered successfully, the Healthier Together programme will go on to save and improve thousands of lives each year.

1.1.3 Extensive work has taken place under the leadership of the NHS Greater Manchester Board, and an overview of this, along with a progress report on the development of models of care and details of the next steps are outlined within this paper. This is intended to be the basis for further comment and discussion as part of the on-going engagement process.

1.2 Programme overview

1.2.1 It is set in the context of Health and Care Service Reform across Greater Manchester and a shared ambition of: delivering better outcomes for Greater Manchester residents and patients at lower cost; for more people to remain independent and in control of their lives; and for better quality outcomes from hospital services. We want to provide the best possible quality of services for our population.

1.2.2 As such Health and Social Care leaders support the need to reconfigure hospital services in parallel to the development and implementation of 10/12 new locally derived models of integrated care and more accessible primary care services. This will significantly reduce avoidable and unplanned admissions to hospital and other care institutions; whilst also recognising that for some hospital services, a Greater Manchester wide planning perspective is needed.

1.2.3 Having established the context of the programme in terms of the reform required to the wider health and social care system, the cornerstone of the programme has been to propose new models of delivery across some hospital services in Greater Manchester that require a Greater Manchester wide planning perspective. The newly formed CCGs in Greater Manchester are ideally placed to lead this change.

1.3 Programme benefits

1.3.1 A benefits management framework has been established to help the Healthier Together programme to quantify and monitor the successful delivery of benefits to patients, staff and to the way in which services are run. The framework will allow the value of clinical and quality benefits to be demonstrated to the public, patients, and staff as well as external advisory bodies such as the National Clinical Advisory Team and Office of Government and Commerce. Through this framework, the Healthier Together programme will define outputs, outcomes and benefits, undertake benefit mapping to illustrate the relationships between these and ensure benefit realisation plans are put in place.

1.3.2 The need for change in Greater Manchester has been set out into four strategic outcomes, which include:

- Improve the health and wellbeing of people in Greater Manchester;
- Improve equality of access to high quality care;
- Improve people's experience of healthcare service; and

- Make better use of healthcare resources.

1.3.3 These strategic outcomes have been mapped to what this would mean for patients and the themes which have started to emerge from the pre-consultation engagement with members of the public.

Table 1: Strategic aims and benefits

Strategic Aim	For patients this will mean	Domains/Criteria
Improve the health and wellbeing of people in Greater Manchester	• People will live longer, independent lives. • Variation in experience and access will be reduced through standardisation of care.	• Access • Distance and time to travel • Access to integrated services • Patient choice
Improve equality of access to high quality care	• More care will be delivered in local settings. • Specialist care will be available to everyone. • Local urgent and emergency services will remain in every locality. • People will receive services in different places, this may be closer to home in a GP practice, local community settings or further away for specialist care.	• Quality • Patient safety • Patient experience • Clinical effectiveness • Quality of estates
Improve people's experience of healthcare service	• People will experience care pathways that are evidence based and integrated across social, community, primary, secondary, tertiary and mental health services. • Care should be available locally meaning fewer trips to hospital. • Quality and safety will be improved.	• Clinical evidence base • Adheres to national standards and Greater Manchester agreed standards of care • Is responsive to patient needs
Make better use of healthcare resources	• A new system will enable reduction in waste and invest to provide services that are sustainable, viable and cost effective. • Increase in patient's independence and responsibilities of health and social care.	• Sustainability • Capital expenditure • Transition costs • Value for money • Workforce

1.3.4 Expected benefits can be identified, examples of which are below:

- Increased patient satisfaction, empowerment and self care;
- Improved access to services;
- Shorter waiting times at GP and hospital;
- Reduction in A&E attendances;
- Improved outcomes;
- Reduction in re-admission rates;
- Shorter lengths of stay;
- Reduction in number of Serious Untoward Incidents;
- Improved recruitment and retention of staff;
- Workforce benefits (reduced turnover);
- Best practice clinical standards introduced and measured; and
- Reduction in variability across Greater Manchester.

1.3.5 The next phase in this work includes: the agreement of these domains/criteria; the establishment of a baseline; and the identification of data sources to allow the benefits identified to be quantified and therefore measured and tracked.

2 Case for change and vision

2.1.1 Greater Manchester is constantly evolving with growing and vibrant communities, and on average local people are living longer than ever before. This is good news, but it is one of the factors putting severe pressure on our health system which was designed for the needs of the last century.

2.1.2 The overall Health and Social Care economy in Greater Manchester is known to be in the region of £6bn; £5.2bn is spent by the NHS and a further £1bn by Local Authorities. 50% of the NHS annual expenditure is in the Acute sector, which in Greater Manchester comprises nine NHS Acute Trusts (one being a specialist cancer hospital) and five Community and Mental Health Trusts. In addition there are many care homes (approx. 600), care in the home providers (approx. 350) and community providers (approx. 500).

2.1.3 Over the last 18 months, over twenty clinical congresses involving hundreds of clinicians have considered the issues facing our health system. They have explored the potential solutions to ensure services remain high quality, safe and cost effective for future generations. This work, which has been based on evidence and best practice from around the world has developed into an overarching clinical Case for Change and Vision.

2.1.4 This provides an overview of the Greater Manchester health and care economy, clearly identifying strategic areas where change is needed in order to save thousands of lives and improve people's recovery rates.

2.1.5 As our population ages, the amount of people living with multiple long term conditions such as diabetes and Chronic Obstructive Pulmonary Disease (COPD) is increasing. A lack of capacity in community and primary services means people with these conditions end up in hospital rather than being treated elsewhere. Many elderly people are living and dying in residential care and hospitals even though this is not what they want for themselves simply because there is nowhere else for them to go for treatment. This is increasing the pressure on our hospital and the social care system.

2.1.6 More care therefore needs to be delivered in primary and community care settings or in patient's own homes, which will be more convenient for patients and their families and will empower people to help manage their own health and remain independent and in control of their lives.

2.1.7 There is a common understanding across the health and social care system that we need new service models to keep people who do not need hospital services closer to their own homes and communities providing truly integrated or "joined up" care. At the same time, we know for those people who do need hospital services, whilst many of our hospitals provide excellent care, care is variable, and not all meet best practice standards and guidelines because too many attempt to do everything. We already have evidence that by centralising care for a range of specialist conditions such as stroke and cancer we can achieve much better results for patients due to the availability of more experienced clinicians, more specialised equipment and better aftercare. This is also a far more efficient and effective use of public money.

2.1.8 The Case for Change, supported by the eight clinical work streams described in 2.2.1, provided the foundation and first step of the Healthier Together programme. This along with our wide-ranging public engagement work led to the development of our vision which is:

"For Greater Manchester to have the best health and care in the country."

2.1.9 Building on our previous success of service transformation in Greater Manchester, our current system can be reorganised in a way to help us achieve our vision by providing the right care in the right place at the right time to meet the individual needs of our patients. This is described in detail in the Vision document.

2.2 Development of the model of care process

2.2.1 The Greater Manchester Clinical Strategy Board identified the following eight work streams, which leading clinicians have been working on to determine the current problems, how best practice might be achieved and to set key clinical standards that all care providers should meet.

- Surgery
- Acute medicine
- Urgent and emergency care
- Primary care
- Long term conditions
- Women's and Children's
- Cardiovascular
- Cancer

2.2.2 For each of these work streams a Case for Change document was developed. Each of these aimed to identify the current position within Greater Manchester and key areas of focus, utilising existing national policies and guidance and published data relating to activity, outcomes and performance. The individual Case for Change documents were approved and endorsed in August and September 2012. As the clinical congresses developing these work streams advanced their thinking, 'Vision' documents were developed. These established an understanding of where services in Greater Manchester are now, where we want them to be, and what gap remains in achieving this. The aim of this process was to create strategic frameworks to aid the future commissioning and provision of these services. The individual Vision documents were approved and endorsed in October and November 2012. The overarching Case for Change and Vision documents described in Section 2.1 were approved by NHS Greater Manchester Board in September 2012 and January 2013 respectively.

2.2.3 The work undertaken on these areas has facilitated informed discussions about the future for these services. Individual sets of standards and models of care have been agreed by Clinical Congresses, directly supported by the Healthier Together Programme, for Emergency General Surgery and Urgent, Emergency & Acute Medicine and are under development for Women's and Children's services. These have informed the development of an overall *'Outline Model of In-hospital Care'* which when finalised will provide the building blocks for developing options for future hospital configuration in Greater Manchester (Section 4.3). The Clinical Reference Group which provides clinical leadership to the Healthier Together programme has suggested that additional standards may also need to be clinically agreed to inform the 'Final Model of In-Hospital care' (potentially including for example Specialist Cancer Surgery services).

2.2.4 The Healthier Together programme is also working with clinical congresses to support the development of outline models of care for Primary Care and Frail Elderly services. It is proposed that in future this be taken forward, with partners, alongside the development of Integrated Care plans (section 4.1)

2.2.5 The development of standards and models of care has been dependent on the scale of change required and level of organisational coherence in place for developing the service across Greater Manchester. There is a view that the required scale of change identified for some of these work streams e.g. cardiac imaging, mental health (Figure 1) would not result in substantial variation to current acute hospital service provision and by implication the need for these areas to be considered in the development of options for formal public consultation. It would be possible for the work streams in these areas to be taken forward by the Strategic Clinical Networks (SCN) being developed across Greater Manchester.

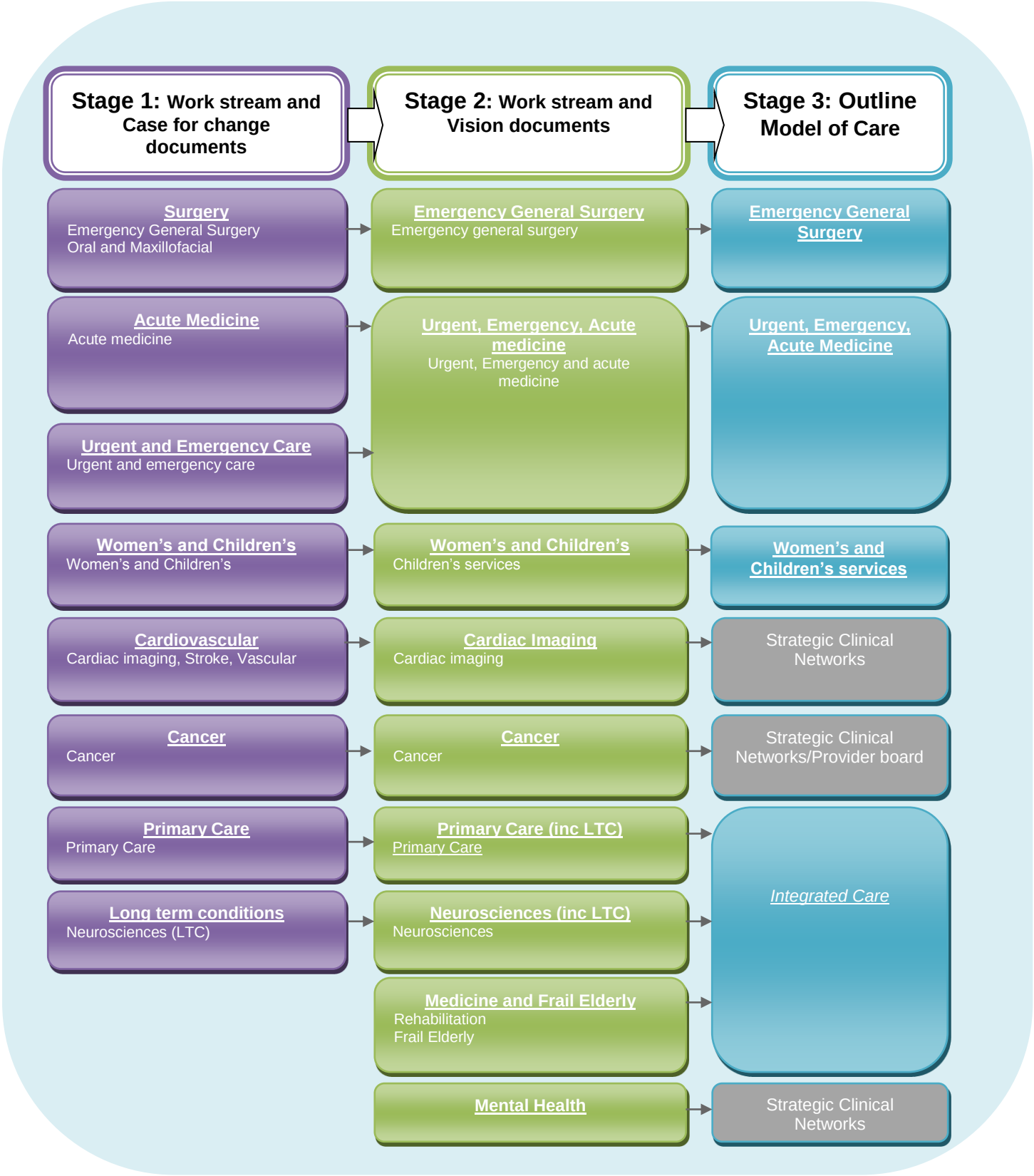
2.2.6 The advice and proposals outlined above will be considered by a committee of all commissioners, and a decision made on where additional standards are required to inform the 'Final Model of In-Hospital Care' (e.g. Women's and Cancer services), how Integrated Care models are taken forward

with partners and how service transformation will be taken forward for the other in-hospital areas originally covered by this programme. It is expected that work on any additional standards, subject to the decisions required above, could be completed before the end of June 2013 after which stress testing and the development of options for future hospital configuration can be completed.

2.2.7 In the interim the work streams which are being taken forward by the Healthier Together Programme, are as follows:

- Emergency General Surgery;
- Urgent, Emergency and Acute Medicine;
- Women's and Children's; and
- Integrated Care (working with partners).

Figure 1: Healthier Together work stream development



3 Communication and engagement

3.1 Outline of the key stakeholders

3.1.1 Health is everybody's business, so our list of stakeholders is extensive. These include: patients and the public; all staff and clinicians working in primary, community and social care; and a wide range of partner organisations including local authorities, the third sector, trade union groups, the business community and the media. Effective communications and engagement is critical to the success of the programme and we are committed to providing this.

3.1.2 Discussions with clinicians and other partners have been ongoing for 18 months and these have shaped our proposals including the development of the Cases for Change and each of our Visions.

3.1.3 Discussions with the public began in earnest in February 2012, to ensure that local people have had the opportunity to influence and shape the future of health services from an early stage.

3.2 Outline of the issues raised through pre-consultation engagement

3.2.1 A series of workshops and meetings have taken place across Greater Manchester with around 1,000 local people attending these to date, with many more planned over the coming months. A range of presentations, interactive round table discussions and question and answer sessions were delivered by clinicians leading the Healthier Together Programme, clearly demonstrating the clinical leadership and strong commitment for delivering the programme in partnership with clinicians, patients and key partners.

3.2.2 Key messages arising from these so far are:

- Most people said they understood the rationale for change;
- Most said they agreed with the need for change;
- More emphasis needs to be placed on encouraging people to take responsibility for lifestyles;
- Most agreed easy and quick access to primary care is vital; and
- People want access to a senior medical opinion 24/7.

3.2.3 This feedback has been factored into the programme benefits outlined in Section 1.3.

3.2.4 We have recruited patients to a series of patient panels to support the public discussions leading up to the anticipated public consultation later this year. An External Reference Group made up of representatives from the community sector, patients and carers, Local Involvement Networks (LINks) and an independent Chair are overseeing and advising on the pre consultation and the formal consultation processes.

3.2.5 We have also had extensive engagement with partners and have co-developed a set of principles with the Association of Greater Manchester Authorities (AGMA) upon which any changes to the health and social care system will be based (see Section 4.1.1).

3.2.6 An on-going conversation will continue across Greater Manchester with a range of local patients, public, groups and the voluntary and community organisations, targeting specifically those who are deemed hard to reach and don't always have a voice. The aim is to have open, honest, transparent conversations about the future of health and care services.

4 Greater Manchester Outline Model of Care

4.1 Delivering Integrated Care across Greater Manchester

4.1.1 Stakeholders across Greater Manchester, including representatives from NHS Greater Manchester, CCGs, Local Authorities, Acute Trusts and others have worked to develop a framework for the presentation of health and social care reform in Greater Manchester as part of a wider public service reform programme.

> *"The future health and social care system will look substantially different and that improved **quality** of health care for Greater Manchester residents will underpin the following **key principles** of a new system:*
>
> - *People can expect services to support them to **retain their independence** and be **in control of their lives**, recognising the importance of family and community in supporting health and well being;*
> - *People should expect **improved access to GP and other primary care services;***
> - *Where people need **services provided in their home** by a number of different agencies they should expect them to **planned and delivered in a more joined up way**;*
> - *When people need hospital services they should expect to receive **outcomes delivered in accordance with best practice standards** with quality and safety paramount – the right staff, doing the right things, at the right time;*
> - *Where possible we will bring **more services closer to home** (for example there are models of Christie led Cancer services delivered from local hospitals);*
> - *For a relatively small number of patients (for example those requiring specialist surgery) **better outcomes depend on having a smaller number of bigger services;***
> - *Planning such services will take account of the **sustainable transport needs** of patients and carers; and*
> - *This may change what services are provided in some local hospitals, but no hospital sites will close."*
>
> *Source: Papers from AGMA Executive, 22 February 2013*

4.1.2 The Association of Greater Manchester Authorities (AGMA) is a voluntary collaboration of the 10 local authorities in Greater Manchester. The AGMA Executive meeting on 22 February 2013 supported this framework and committed to creating partnership opportunities to further debate and development locally.

4.1.3 The Healthier Together vision provides a clear indication of the response required to address the clinical case for change and ensure a viable, safe and sustainable care system across Greater Manchester. Part of this involves redefining the role of hospital care through recognising the increasing specialisation of acute services with clear clinical quality standards in place to ensure the highest quality and safety. However, it has been widely recognised that to deliver better quality, targeted and more responsive local services that achieve a substantial reduction in avoidable admissions to hospital and other care institutions - at a scale never previously achieved - requires a significant shift in the way care is organised, delivered and accessed across the whole system. This includes new contracting models which reward preventative interventions and shifts money across the health and social care system as well as a cultural shift in how care providers work together to provide more joined up care. Patients, individuals and their carers also have a more central role to play in taking charge of their health and wellbeing through structured support for self-care and fulfilling their goals.

4.1.4 There are therefore significant opportunities for partners across health and social care to work in collaboration and partnership to improve citizens' care outcomes and experience of care services by developing "integrated care services" – care that is based around the needs of people and carers that put them in control, that are joined up, and that deliver better outcomes.

4.1.5 AGMA has encouraged closer working between Local Authorities, CCGs and NHS providers in reviewing and further developing models of integrated working. The AGMA Executive has challenged all partners to work together to deliver new models of integrated care working at scale and pace as soon as possible. Additionally, the Healthier Together programme continues to work in conjunction with the Area Team Primary Care Commissioning Team, CCGs and via engagement with the wider primary care community to further develop the characteristics of the primary care offer across Greater Manchester.

4.1.6 We recognise that strong partnerships are the key to the successful delivery of services. We know that at the moment the fact that health and care services are managed separately can create difficulties and gaps that are not in the best interests of the patient or client. Joining up these services will give a far better patient/user service.

4.1.7 **Delivering Integrated Care at scale and pace**

A significant amount of work has already commenced locally across Greater Manchester that demonstrates new ways of commissioning and providing more integrated care through new services, delivery models and joint teams across health and social care. The planning and delivery of these initiatives will continue to be determined locally and will form the basis of Local Integrated Care Plans. However, a significant challenge for Greater Manchester as a whole health and social care economy is ensuring that, collectively, local integrated care models operate at the appropriate scale and pace to deliver maximum benefit to patient/user outcomes and the increased capacity in the community to support the changes required to achieve an effective and financially sustainable care system.

4.1.8 Work across Greater Manchester to date has articulated some of the key challenges and expected characteristics of local integrated care models. These are outlined in Figure 2 below. This reflects the emerging leadership consensus on the different elements of integrated care which are fundamental for health and social care reform. It also highlights the elements of a coherent, overarching integrated care framework for Greater Manchester could be co-designed by partners across health and social care which will help to ensure the robustness, deliverability and scale of Local Integrated Care models.

4.1.9 We would welcome the opportunity to work with our partners to further develop this ‘framework’ for Integrated Care. We also recognise that for this overarching framework to be effective, it is likely to require robust and joint governance arrangements across partners in health and social care. There are a number of options for this and this would need to be explored further.

Figure 2: Key characteristics and challenges for Local Integrated Care Models

7 'challenges' for Integrated Care	
Cross-agency leadership, commitment and governance	Local Authority (political and managerial) , CCG (clinical and managerial) and Acute Trust (managerial and clinical) to new service models focused on substantially reducing avoidable admission to hospital and other care institution
Aligning incentives and funding	An understanding of the costs and benefits across all partners of the new service models being proposed, and the contracting and reimbursement models that would allow decommissioning and new commissioning to occur at a scale
Scale	Local integrated care models need to operate at an optimum scale in order to delivery of sustainable benefits, for example, the need to target new interventions at cohorts of the risk stratified over-65 populations of not 1% or 5% but at least 20% and possibly more.
Impact & outcomes	The outcomes of local integrated care models must be tracked and evaluated in order to ensure that they are delivering the operational, clinical and financial benefits to the care system. This could be done through deploying analysis such as the AQUA/ADASS benchmarking tools to understand the baseline and test the effect of the operation of the local system.
Maximising opportunities for GM-wide initiatives	A recognition of how interventions planned and delivered at a GM level (e.g. NWAS, 111, reconfiguration of some hospital services) will inform the development of the local model.
Patient/Carer Experience	A demonstration of the extent to which patient and carer experience is captured and used to inform future development of the model.
Enablers	A credible plan to address some key enabling functions, particularly: ▪ Data sharing agreements across partners that actually work at service level to support single entry and single access points for different agencies ▪ Workforce development strategy that promotes genuinely integrated working, including joint training and development opportunities ▪ A "total place" consideration of estate utilisation to effect a the necessary shift of activity from hospital and care institution

4.1.10 Service components of Integrated Care

Whilst each local partnership will define its own Integrated Care Model service components, it is likely that there will be commonalities across. A suggested framing of these are outlined in Figure 3. The intention of this is to inform a systematic view of the likely potential components initiatives that could be implemented locally in order to deliver improved care to individuals.

Figure 3: Common components of Integrated Care

Common components	Description	Example services
Accessible & Responsive	Care services will be easily accessible and responsive. Primary Care and GPs should act as 'first port of call' particularly for people with Long Term Conditions	▪ Enhancing the range of services within primary care ▪ Reducing variation in primary care ▪ NHS 111
Providers working together	Health and social care teams will work an integrated way, particularly for the frail elderly and people with Long Term Conditions. Patients and their carers will experience care provided in a seamless way with unnecessary duplication avoided as a result of effective collaboration between those involved in the planning and delivery of care.	▪ Integrated case management across health and social care ▪ Single assessment process, with elements of care co-ordination across agencies
Support for self-care and independence	Patients, individuals and their carers will be supported and empowered to take ownership of their care and well-being so that they are able to live independently and so that have health and social care resources are targeted on the most vulnerable.	▪ Patient education programmes ▪ Expert patient programmes ▪ Systematic use of direct payments, personal budgets ▪ Carers strategy ▪ Assistive Technology
Quick response to urgent needs	There will be rapid access and response to urgent care needs to minimise the reliance on A&E and to ensure that the most appropriate care is provided.	▪ Rapid Response/Intermediate Care teams, aligned to Reablement ▪ Urgent Care centres ▪ Joint urgent response services across health and social care on a 24/7 basis
Planned pathways of care	Agreed care pathways and protocols will be in place to ensure that the patients receive standardised care with reduced variability and unnecessary attendances.	▪ Outpatient clinic redesign ▪ Community clinics
Appropriate specialist and hospital care only when required	Patients will receive appropriate specialist input in a timely manner when required and will only spend the appropriate time in hospital with planned discharge in the community as early as possible.	▪ Early supported discharge service ▪ Hospital at home teams, incl Reablement ▪ Integrated End of Life Care

4.1.11 Settings of care for integrated care

Defining where care could be delivered within an integrated or "joined up" care system will lead to a more seamless service for patients. Figure 4 below shows the potential range of possible settings of care and which services might be provided at each. Clearly, significant work in the near-term is required with commissioners, clinicians and care professionals to fully describe the settings of care, and importantly, the interfaces between them.

Figure 4: Where care could be delivered within an integrated care system

Link to objectives	Where services will be delivered	Example of services offered
▪ Support for self-care, retaining independence and control of health and well-being ▪ Improved access to GP and other primary care services	**Telephone and information technology** 	▪ Advice on self-management. ▪ NHS 111 ▪ Telecare and telemonitoring ▪ NHS direct and triage to GP out of hours or route to admission
▪ Support for self-care, retaining independence and control of health and well-being ▪ Services delivered at home are planned and delivered in a joined up way ▪ More services closer to home	**At Home, incl. Care Homes** 	▪ Community services ▪ Rapid response teams ▪ Integrated teams working across the system as a whole
▪ Improved access to GP and other primary care services ▪ More services closer to home	**GP Practice** 	▪ Core primary care services
▪ More services closer to home	**Federated or networked services** 	▪ Primary care extended hours. ▪ Diagnostics ▪ Delivery of multi-disciplinary care
▪ More services closer to home	**Community Hub such as health centres** 	Services may include: ▪ GP services ▪ Outpatients ▪ Diagnostics ▪ Access to dentistry, optometry and pharmacy services. ▪ Social care ▪ Out of hours service ▪ Therapy ▪ Rehabilitation
▪ Clinical outcomes delivered in accordance with best practice standards with quality and safety paramount ▪ Sustainable transport needs of patients and carers ▪ Better outcomes depend on having a smaller number of bigger services	**Spectrum of acute hospitals** 	Services may include: ▪ Trauma Unit/Centre ▪ A&E with selective/unselective acute medical and surgical take ▪ Acute Medical Unit ▪ L1/L2/L3 Critical Care ▪ Anaesthetic cover

4.1.12 **Next Steps**

It is clear that there is a significant amount of work to do to accelerate the further development of a Greater Manchester-wide view of integrated care across health and social care partners that supports and aligns to Local Integrated Care models. Some immediate next steps include the following:

- Accelerated engagement with CCGs, Local Authorities, Directors of Adult Social Care, acute and community providers to participate in the co-design of a 'Greater Manchester-wide framework' for integrated care;
- Engagement with CCGs to understand progress with development of Local Integrated Care Plans, particularly aspects where commissioned services are likely to have a direct impact on acute activity reductions; and
- Continued engagement through the Primary Care Clinical Congress and Summit for further development of the primary care offer and the potential for a '10-point plan' for enhancement.

4.2 Possible implications for Primary Medical Care

4.2.1 The Primary Care Clinical Congress, as part of the Healthier Together programme, has agreed a vision for Primary Medical Care and is now focused, along with partners, on how this could be further developed. The key objectives for this work are proposed as:

- Reviewing the primary care vision against the current evidence base to ensure the Greater Manchester vision is sufficiently ambitious to deliver an enhanced primary care offer;
- Address variation in primary care and improve quality of outcomes for the whole Greater Manchester population;
- Broadening the scope to ensure maximisation of opportunities within Dental, Pharmacy and Optometry; and
- Ensuring primary care's contribution to improving population health and the reduction of health inequalities.

4.2.2 The Healthier Together programme has defined what Primary Medical Care needs to help achieve as:

- Engagement and empowerment of patients and their carers to self-care and take control of their health and wellbeing;
- Enhanced integrated care across Greater Manchester to deliver improved outcomes for the whole population;
- Systematic and proactive management of chronic disease to improve health outcomes, reduce inappropriate use of hospitals and positively impact on health inequalities;
- Reduce unnecessary hospital attendances and admissions; and
- Population-based approach to commissioning - directing resources to the patients with greatest need and redressing the 'inverse care law' by which those who need the most care often receive the least.

4.2.3 Examples of how this could be achieved:

- Patients and their carers are involved in the design of the primary care system and as partners in the management of their own conditions and health needs;
- Integration between primary, social and community care forming part of an overall approach to pathway based commissioning;
- Identification of patients with the highest set of needs e.g. those with long term conditions to ensure these are optimally managed in primary care with interfaces with community services, secondary care and mental health clearly defined and managed;
- Ensure that primary medical care facilities are fit for purpose and take appropriate action if not;
- Development of a systematic approach to primary prevention is implemented, e.g. with regard to alcohol, smoking, exercise;
- Effective management of mental health needs;
- Effective arrangements for primary care management of end of life care;

- Effective medicines management; and
- Managing elective and urgent care activity.

4.2.4 Those involved in the commissioning of primary care need to understand how the whole health system can be transformed to deliver the changes required. A draft 10-point plan to enable this systematic and wide scale change at sufficient pace and scale is being developed for further discussion across the primary care community.

DRAFT 10- point plan

1. Clear primary care commissioning plan for 2013/14.
2. Review of primary care "discretionary" spend to ensure maximum health gain for the population and appropriate system incentivisation.
3. Transfer of resource from secondary to primary care to deliver enhanced management of long term conditions. This may require initial pump priming to ensure accelerated pace of change.
4. Explore opportunities for increased working across practices.
5. Provision of support for GPs to help improve health literacy of the population and increase prevention.
6. Investment in local technological solutions to improve sharing information between care professionals as well as enable patients to access their own records.
7. Development of clear patient pathways and access points across Greater Manchester.
8. Additional support where required for CCGs to plan and implement effective integrated care strategies for their local population.
9. Implement a standardised enhanced role for primary care nursing and create an investment programme to maximize the currently varied and underutilised workforce.
10. Support to increase the amount of training placements for GPs across Greater Manchester.

4.3 Secondary care services

4.3.1 The Greater Manchester Case for Change and Vision clearly identify the need to have safe and sustainable secondary care services in hospitals that will meet the demands of current and future generations.

4.3.2 It is recognised that a new model of care is required in a number of key areas and this will change the nature of our hospitals across Greater Manchester. Figure 5 identifies the building blocks that may contribute to the development of future services. The development of clinical standards will reinforce the requirement for services to provide the same high standards during the day, night and weekend in Greater Manchester.

4.3.3 A key component of this new integrated service will be linking hospital sites and creating single services that will mean patients being cared for in a joined up way, with professionals providing services at different locations based upon patient needs. The combination of the different types of hospitals proposed recognises the different needs across Greater Manchester - that each area has

a differing population, demographic geographical spread and transport links; as well as taking into account the existing hospital estate and equipment, previous reconfigurations and required clinical interdependencies.

4.3.4 Figure 5 outlines the building blocks to the future secondary care services. These are based upon the clinical outline models of care which have been developed and will be enhanced as further work and discussion takes place with the public and patients. However, it is proposed that this foundation will ensure the identified standards and programme outcomes are achieved.

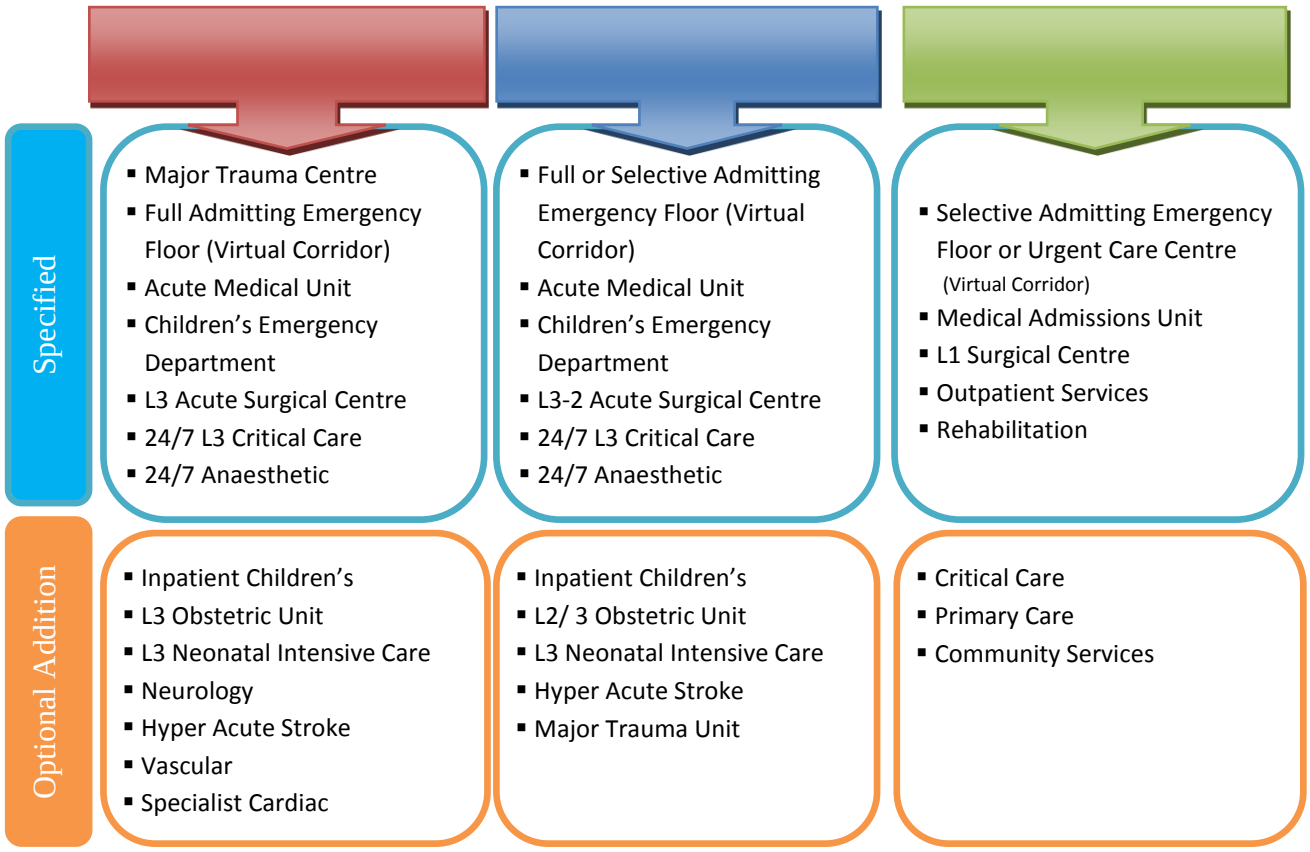
4.4 Urgent, Emergency and Acute Medicine

4.4.1 The importance of an effective emergency service cannot be underestimated for a conurbation such as Greater Manchester as an increased ageing population is balanced with rapid developments in the care of acutely unwell patients. However, a recurrent theme from the public and patient panels we have held as part of our pre-consultation, is the often confusing and fragmented approach to urgent and emergency care that is ultimately manifest as greater use of Emergency Departments. A&E is easily recognisable with many members of the public understanding that they are open 24/7 and are operated by skilled doctors, nurses and professionals (although this is not always the case particularly in the evening and at weekends). This is against a backdrop of perceived poor access to primary care and alternative services. Recent changes to patient pathways aimed at challenging this (deflection schemes) have had limited success and there is little published evidence to support this approach.

4.4.2 The Healthier Together programme proposes that the model of care for urgent, emergency and acute medicine is built on the premise that a **Single Service** for each area will reduce the duplication, confusion and inefficiency in the service. Each local **Single Service** would be designed to match local need; however it is proposed that the following services could be commissioned in a unified way as a **Single Service**:

- Emergency departments (including Children's services);
- Acute Medicine Units; and
- Out of Hours Primary Care Services.

Figure 5: Building Blocks based on Outline Models of Care

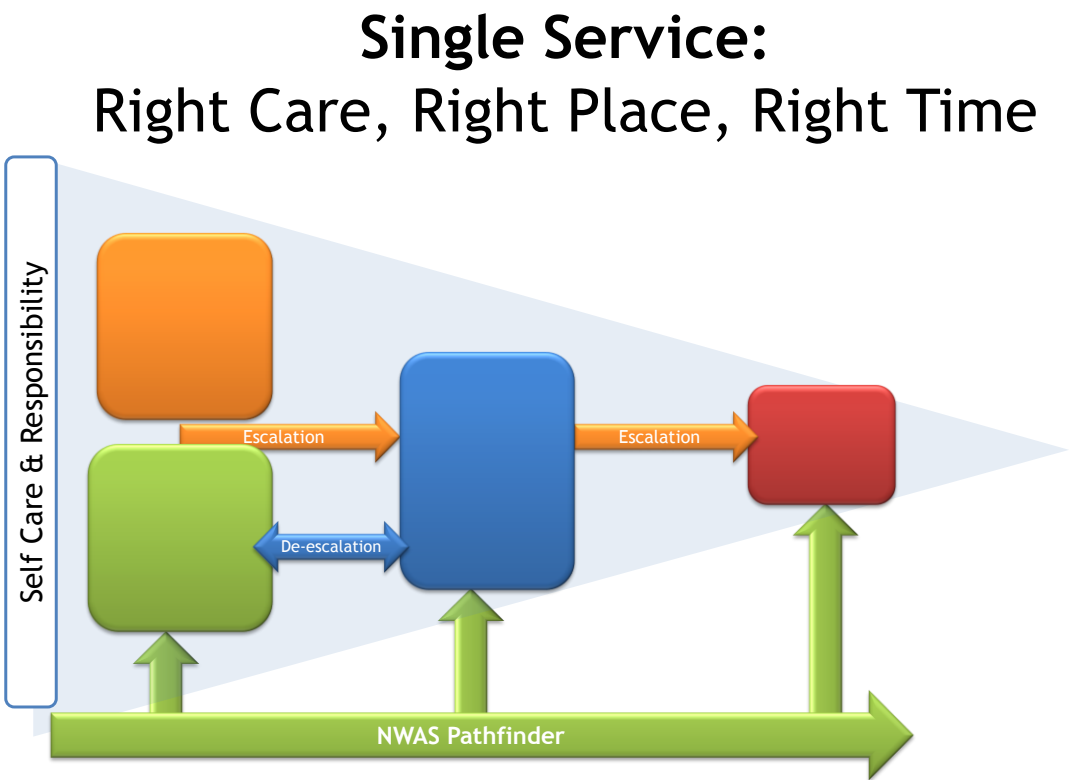


4.4.3 Additionally, the following services would enhance the overall approach if they were included in the **Single Service** model:

- Social care services;
- Community and support services (including third sector);
- Primary Care;
- Mental Health Services; and
- Ambulance/Transport services.

4.4.4 A key principle of the **Single Service** is the connection of all elements of the service to make sure every patient has access ***to the Right Care at the Right Place and the Right Time.*** Furthermore, there should always be the aim to de-escalate a patient's situation at the earliest opportunity so that most care is provided locally, and only when clinically necessary that the Ambulance Service and hospital care is provided (Figure 6).

Figure 6: The Single Service: Right care, Right place, Right time



4.4.5 To enable this model to achieve the required urgent emergency and acute medicine standards it is proposed that each **Single Service** combines the right balance between different types of hospital to ensure a safe and sustainable service (Figure 7). Fundamental to the success of this is the enhanced role of the NWAS Pathfinder and the clear identification of each hospital site for ambulance crews. The success of each site within the **Single Service** also relies heavily on the interdependencies with other services and the efficient flow of patients.

4.4.6 As part of the model an **Emergency Floor** will allow early identification of a patient's presenting condition, rapid diagnostics and a multi-disciplinary plan of care to be enacted. This concept recognises the need to stream and triage appropriate presenting cases and organise the initial phase of care in a co-ordinated and unified way.

4.5.6 In order to achieve the Greater Manchester standards it is clear that a collaborative workforce and service approach is required, underpinned by a single governance structure. To assist with this approach a **Virtual Corridor** is proposed, linking each site with the **Single Service** (Figure 8). This approach is currently effective for a number of key specialties and allows the consolidation of expert service, and the effective delivery of the patient to them.

Figure 7: A Single Service and Interdependencies

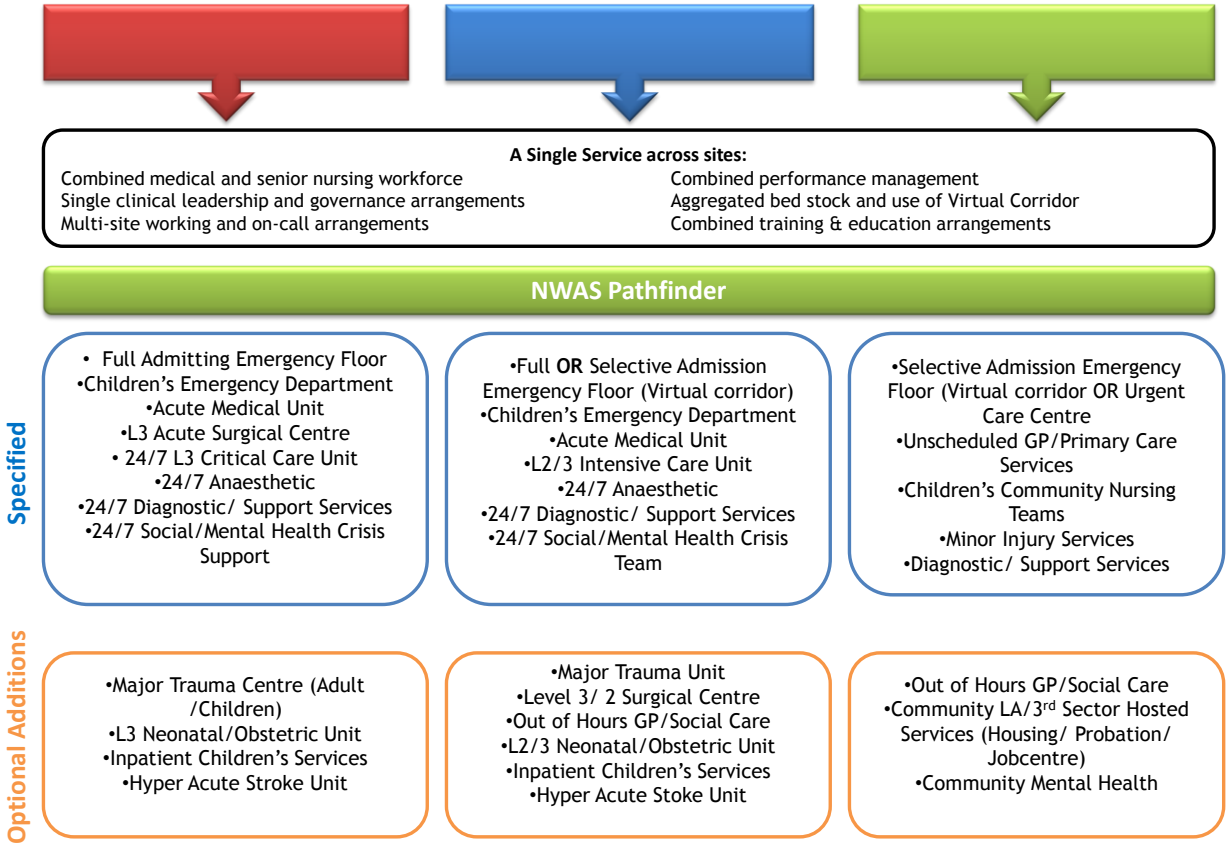
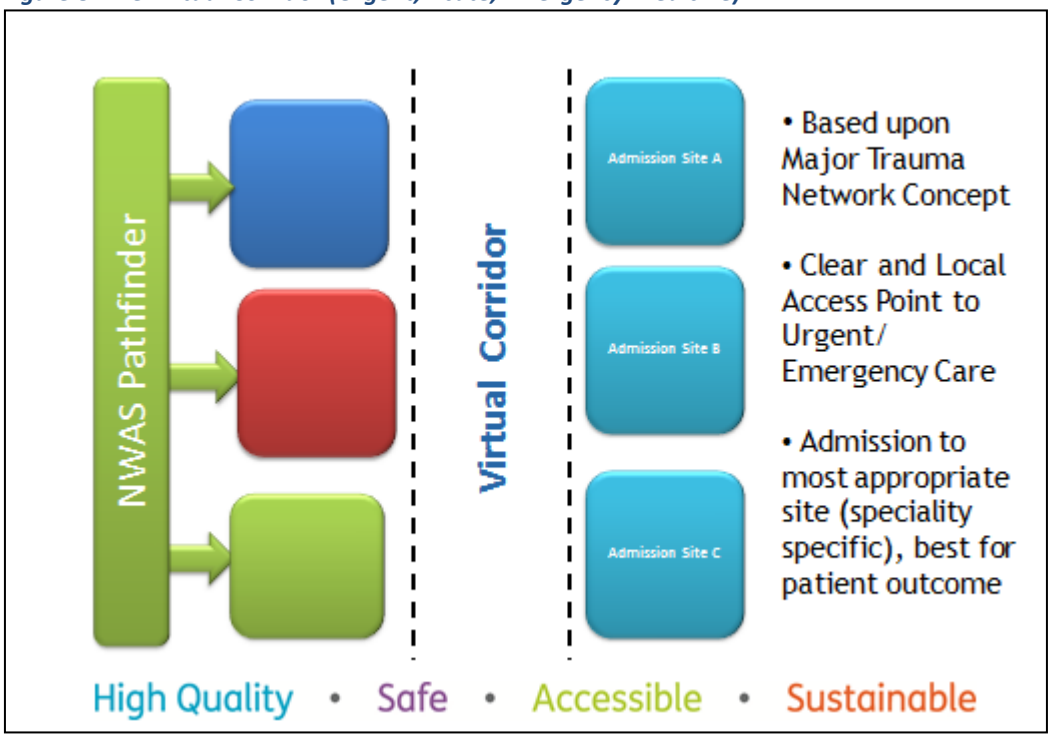


Figure 8: The Virtual Corridor (Urgent, Acute, Emergency Medicine)

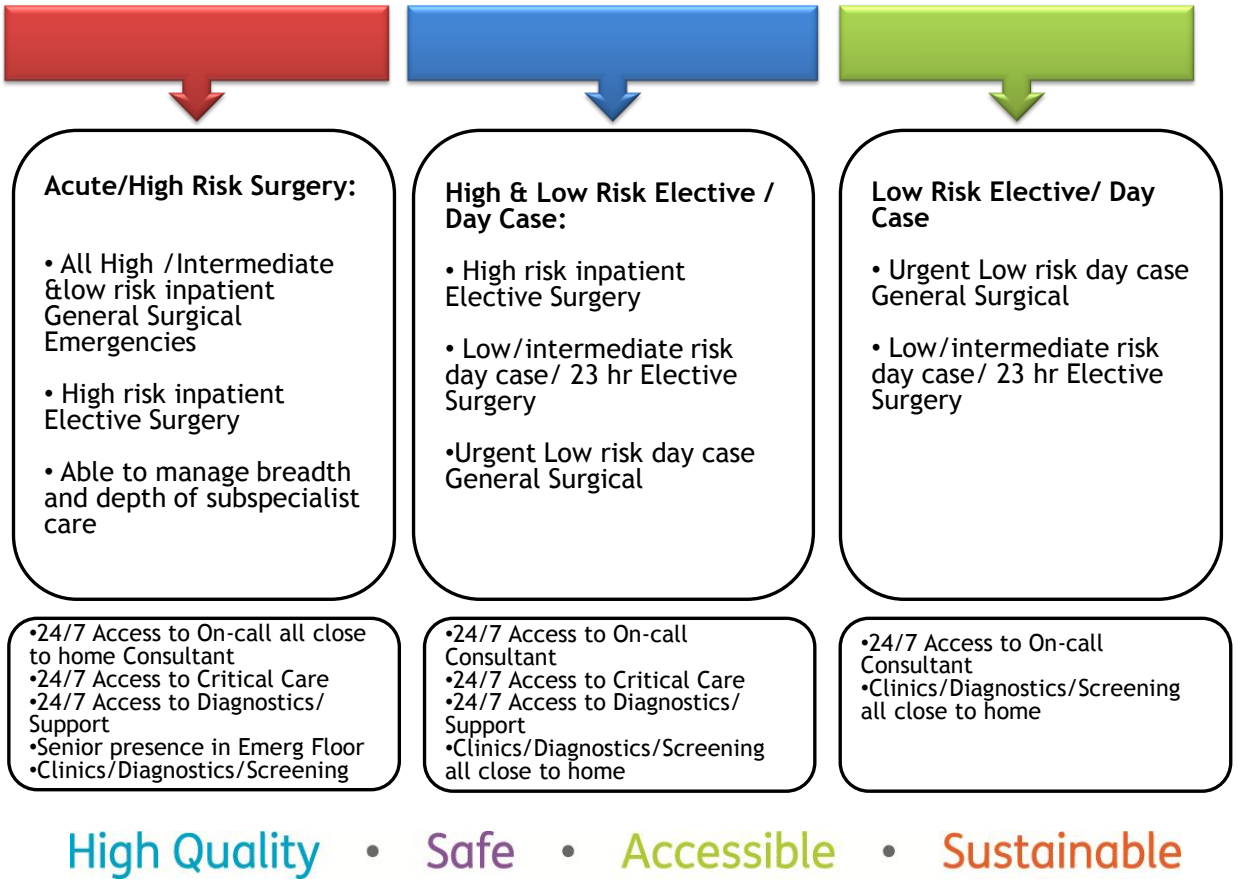


4.7 General Surgery

4.7.1 To fulfil the Emergency Surgery Vision and the Greater Manchester standards, it will be necessary to change the current model of care and combine existing services in a single and unified manner. The Healthier Together programme proposes that the model of care for general surgery is built on ensuring the urgency of management and seniority of staffing is determined by patient risk. To enhance this principle, it will mean many more operations will be carried out by Consultants and critical care beds will be available for all high risk cases; which will allow patients to be suitably managed on integrated pathways led by Consultant decision making, in conjunction with other services, specifically GPs.

4.7.2 The proposed model of care for general surgery follows a similar principle as described earlier, whereby single sites and services are combined as a **Single Service**. This would consolidate excellence at an Acute Surgical Centre which would deal with all high risk general surgery emergencies; and would allow the creation of surgical centres specialising in day case and elective services (Figure 9).

Figure 9: Outline Model of Care



4.7.3 To enhance the proposed **Emergency Floor** concept described earlier a senior surgical decision maker would be present to ensure rapid response and appropriate decision making. These surgeons would be free from operative responsibilities and would be responsible for liaison with the Emergency Floor, Integrated Pathway management with Primary Care and the Virtual Corridor transfers. The establishment of this model would allow surgeons to be dedicated to operations and ward rounds; uninterrupted with competing priorities.

4.7.4 The **Virtual Corridor** concept is an innovative one and will ensure that patients receive their care from the most relevant medical or surgical practitioner, in the best location to give them the best possible chance of survival and good quality of life after their illness or injury.

4.8 Workforce

4.8.1 The new models of care are all designed to provide enhanced levels of specialist, senior medical and nursing staffing. This is both in terms of more on site presence than would be found during "traditional hours" and with higher levels of seniority. The importance of having the most senior "decision maker" actually physically present in the hospital is now widely recognised as one of the most important attributes to providing safer and prompter care to the most seriously ill and vulnerable people.

4.8.2 However, we are trying to achieve this at a time when we no longer have enough consultants to meet acceptable quality standards. There are a several reasons for this. The number of trainee doctors is reducing nationally. There have been significant changes in terms of the immigration rules leading to a reduction in the number of speciality doctors available to Trusts. Trainee doctors are now obliged to meet with the European Time directive which has meant a reduction in the hours that they can work.

4.8.3 National work on this area is being led by Sir Bruce Keogh, Medical Director, NHS Commissioning Board, which is described fully in a paper called "Seven day consultant present care" published by the Academy of Medical Royal Colleges in 2012. The current baseline data available indicates that nearly all the hospitals within Greater Manchester will not be able to meet the recognised national standards for high quality services without a radically different approach to providing these critical services. It is clear that workforce, particularly Consultant medical workforce, will be a key determinant for developing the details of the model for acute services across Greater Manchester.

4.9 Women's and Children's services

4.9.1 In developing the Case for Change and Vision for Greater Manchester Children's services, it was recognised that the Making it Better (MiB) reconfiguration programme, has significantly strengthened the safety and sustainability of Women and Children's Services across Greater Manchester. Some key examples of success include the increase in consultant delivered care for paediatrics, obstetrics and neonatology and large-scale expansion of midwifery numbers and community children's nursing teams in every locality.

4.9.2 Since the approval of the MiB programme in 2007 and the completion of the large-scale service reconfiguration programme in 2012, there has been further evidence produced by the Royal College of Paediatricians and Child Health (RCPCH) which would support further redesign of Children's Services. The RCPCH policy document; Facing the Future (2011) has developed a number of interlocking proposals so acute services are strengthened and made safer. These are as follows:

- A reduction of inpatient sites across the UK so that acute care can be concentrated on fewer sites with an expansion of short stay paediatric assessment units;
- An expansion of consultant paediatricians aligned with an increase in consultant delivered care;
- An expansion in the number of GP trainees;
- An expansion of nurses with extended or advanced roles; and
- Reduction in the number of paediatric trainees.

4.9.3 An initial audit of the Facing the Future Standards across Greater Manchester has highlighted large variance across each service and a need to enhance the current model of care.

4.9.4 Furthermore, it is recognised that proposed changes to urgent, emergency and general surgery will have a significant impact upon children's services. In addition, any proposed changes to children's services and general surgery will have an impact upon women's services (Gynaecology & Obstetrics).

4.9.5 Therefore to ensure that Women and Children's services meet national standards there is an acceptance by clinicians of the concept of *critical mass* whereby clinicians; doctors, midwives,

nurses need to see and treat a particular number and type of patient in order to maintain their clinical skills. This is further compounded by the seasonal variance of children's services whereby summer months see consistently lower admission rates across all Greater Manchester sites.

4.9.6 In order to develop an outline Model of Care for Women and Children's Services Greater Manchester standards will be developed and audited against all current providers. Aligning with the other clinical work streams the outline Model of Care will provide an integrated service between secondary and primary care to ensure and enhance the safety and sustainability of the service.

5 Finance

5.1.1 Whilst main drivers and strategic aims of Healthier Together are improving the health and wellbeing of people in Greater Manchester, improving equality of access to high quality care and improving people's experience of healthcare service; making best use of healthcare resources is also a key driver if we are to maintain a sustainable system.

5.1.2 Health and care services are under unprecedented financial pressure, and we know that this will increase in coming years. If we do not act now the system will become steadily less sustainable and some of our services and probably entire hospitals will fail. This section will explain why change is needed – doing nothing is not an option.

5.2 The challenge for healthcare commissioners

5.2.1 Demand for health services is growing due to a wide range of factors including an ageing population, higher patient expectations, better technology, inappropriate use of A&E and other health services by patients, unhealthy lifestyles and increased referral rates from Primary Care. This is resulting in many providers 'over-performing' on their contracts with commissioners (i.e. commissioners having to pay for more activity than planned).

5.2.2 Demand can be managed to an extent and there are a variety of existing initiatives known as QIPP schemes (Quality, Innovation, Productivity and Prevention) aimed at reducing costs whilst maintaining quality and safety standards through best practice and innovation and improving efficiency. For example, measures have been put in place to help GPs decide whether patients really do need to be referred into hospital or could be treated elsewhere, and the number of procedures of limited clinical value has also been reduced. These include things like tonsillectomies and adenoidectomy which used to be common place but have been replaced by less intrusive treatments which are just as if not more effective.

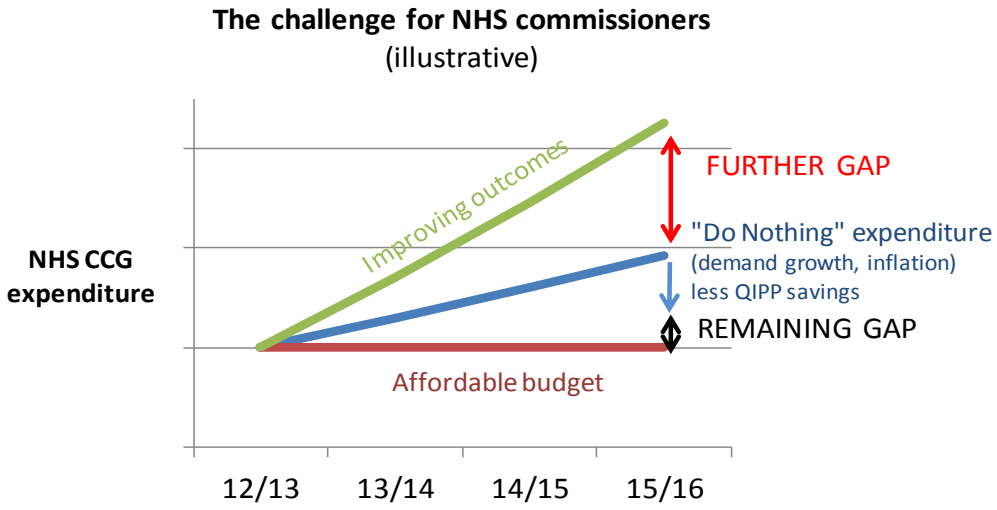
5.2.3 This is not about depriving patients of necessary treatment, but we also understand there is a difference between demand and need. Commissioners must ensure that they find ways of covering current unmet need such as undetected diabetes 2 which can have significant consequences for patients if left untreated. They also know that there are many patients in hospital who have a need for better care provided closer to, or at, home.

5.3 The challenge for Clinical Commissioning Groups

5.3.1 The challenge for CCGs will be that the limited increases or real reduction in NHS funding over the next few years. This will not be enough to cover demand growth (even if we manage this), cost inflation (since the acute tariff only covers a proportion of total expenditure), and investment in better outcomes for patients. This is why significant savings need to be achieved (Figure 10).

5.3.2 The 12/13 QIPP plan for the PCTs is £92m which only goes some of the way to cover the above factors and only in the short term. Experience tells us that one coordinated QIPP programme across Greater Manchester will achieve a greater level of patient benefits and financial savings than individual plans.

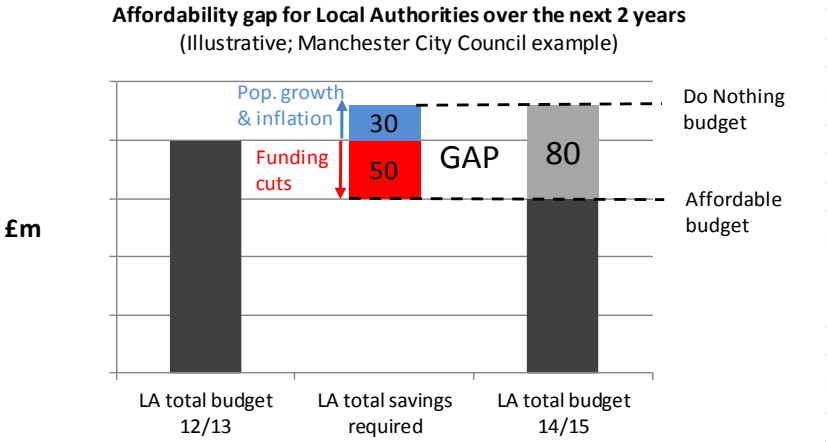
Figure 10: The Challenge for NHS commissioners



5.4 The challenge for Local Authorities

5.4.1 The picture for Local Authorities is similar but they face an even more stark reality as they are suffering absolute term reductions in their funding. The following illustration applies to Manchester City Council's total budget, where £80m needs to be saved over the next two years. There will inevitably be a corresponding impact on their health and social care spend (Figure 11).

Figure 11: Affordability gap for Local Authorities over the next 2 years



5.4.2 As this example is for only one of ten of the Local Authorities within Greater Manchester, the overall impact is far higher. There is therefore considerable potential for an adverse impact on Local Authorities interventions designed to reduce avoidable admissions of patients into hospital. This is why a whole system approach to reform services is required.

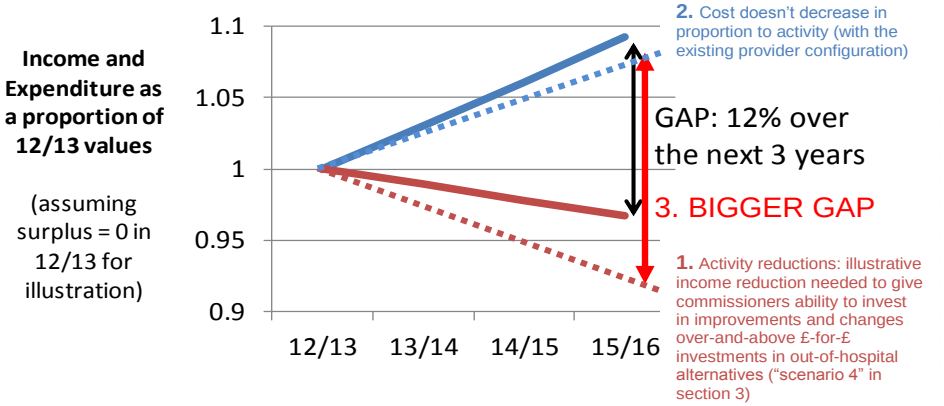
5.5 The scale of the financial challenge for healthcare providers

5.5.1 Providers have challenging savings targets to remain financially sustainable, just to deliver the same activity levels year on year. Although provider costs increase each year, the amount providers receive for their activity remains the same. Therefore, the cost per unit of activity needs to continually decrease, currently by more than 4% each year, for providers to remain financially sustainable. This is before taking into account further reductions to income arising from shifts in activity out of hospital to provide more convenient care for patients closer to home, or taking into account increases in costs to meet specific new or higher standards set around service inputs.

5.5.2 Overall, economic forecasts and sector-specific intelligence suggest that after 2015/16 there will continue to be an annual financial challenge of at least these levels confronting the funding and delivery of healthcare in England. Further efficiencies are therefore inevitable (Figure 12).

5.5.3 At the same time, commissioners need to reinvest resources in improvements which puts further pressure on providers, therefore, individual acute providers are not financially sustainable in their current configuration. The gap for acute providers is even bigger when we consider the requirement for commissioners to move some care, and therefore some funding, out of hospital and into the community, in the best interests of patients.

Figure 12: Income and expenditure as a proportion of 12/13 values



5.5.4 With the existing configuration of our hospitals across Greater Manchester, this scenario is unsustainable at individual provider level. The scale of year-on-year impacts upon existing hospitals' cost bases and the obvious need to reduce staffing costs and numbers would very quickly become incompatible with maintaining proper standards of front-line clinical staffing levels. Without action now this could lead to the need for some very damaging cuts in service provision.

5.5.5 Given that proper staffing levels must be maintained in order for individual Trust Boards to retain a robust focus on patient safety, this incompatibility would then manifest itself as rapidly 'snowballing' levels of hospital deficits. As is already evident from experience elsewhere in England, the practical impacts and manifestation of these deficits would not be evenly spread. Individual hospitals – and thus their services as currently configured - would rapidly and visibly become unsustainable and ultimately fail. We cannot sit back and let this happen.

5.5.6 In addition, improving clinical outcomes and implementing national policy and standards cannot be achieved with existing service models.

Improving the standard of delivery is a major cost pressure particularly in the two key areas of consultant workforce standards, and patient experience:

- **Meeting the workforce standards for consultant availability and cover; consultant delivered care; and consultant led care.**

- **Improving the patient experience by improving standards,** for example improved include single sex ward accommodation, providing privacy and dignity, and adequate time to care.

5.7 The key financial considerations around the transition

5.7.1 Shifting activity between acute providers, and from acute to the community, has associated transition costs.

- **Capital investment will be required.** The current condition and suitability of estates (particularly if they are to be re-purposed) will result in capital expenditure requirements. Investment is needed to re-purpose facilities.

- **There will be double-running costs during the transition.** For example, before workforce and activity can be moved from an acute setting to the community, the community service needs to be ready.

- **Need to release excess estates costs quickly and successfully to minimise the cost impact.** Where estates and facilities do not support the best standards of care they need to be released.

5.7.2 **Pump priming funding will be required over a short bridging period** – and there is likely to be a need to achieve savings to fund this in full.

5.7.3 The future delivery model needs to be tested primarily against commissioner affordability, coupled with evidence that providers can deliver the revised pattern of services from within Payment by Results (PbR) tariffs which are evolving and that the revised 'start-point' has resilience and sustainability designed into it, to deal with variations over time.

5.8 Healthier Together will have a benefits-driven approach to developing options for change, with financial hurdle criteria to ensure that the options are affordable

5.8.1 Benefits and Finance together will drive a robust and exhaustive process to develop and evaluate the right options for change. This will ensure that the recommended option will be the best way of improving patient care while contributing to financial balance.

5.8.2 There are three main types of benefits:

- **Patient benefits** (access/ quality/ closer to home) - *additional investment/costs required in community settings would partially offset savings in acute*
- **Clinical benefits** (outcomes/ KPIs/ meeting standards) - *additional investment/costs required as outlined earlier*
- **Operational benefits** (e.g. reduced unscheduled attendances and emergency admissions, existing activity delivered more efficiency, eliminated duplication and reduced overheads) - *these drive the financial benefits to help close the affordability gap*

5.8.3 The only way of simultaneously achieving the patient and clinical benefits, whilst achieving affordability for commissioners, and financial sustainability for providers, is for Healthier Together to enable most of the savings to be made in non-front-line costs: rationalised estates, reduced management costs and improved operational efficiency.

5.8.4 The patient and clinical benefits (e.g. integrated care pathways, out of hours provision) need to be engineered into a new configuration of providers so that duplicated services and costs can be removed.

5.8.5 To make the transition affordable it will be critical to get the benefits on-stream as quickly as possible. Some benefits (e.g. estates rationalisation) will take longer to realise, but patient benefits should appear as soon as the model of care is changed.

5.8.6 **Ensuring that the change options are affordable during the transition and over the long term** Proposed options will be assessed against financial 'hurdle' criteria, to ensure that only the options which are likely to be affordable during the transition and over the long term are worked up in detail.

5.8.7 We know that system-wide change is needed to meet patient needs and meet the affordability challenge. Therefore financial hurdle criteria should be system-wide, and based on the overarching principles of the reconfiguration:

- **Driven by Clinical and Service Benefits**;
- **Sustainable affordability for the health economy** (at an aggregate commissioner level);
- **Financially viable services**;
- **Resilience to sensitivity and risk**; and
- **Transition to be feasible, deliverable and financially viable** (there must be an ordered and structured management plan for the transition).

5.8.8 Sitting back and doing nothing is not an option that is available to us. The Greater Manchester health economy cannot be made financially sustainable without system-wide organised change. All parts of the system rely upon one another to function efficiently and cannot achieve financial balance and meet quality standards by acting in isolation. It is our responsibility to ensure that the people who live here are aware of this and help to shape the solution for the whole of Greater Manchester rather than waiting for individual providers to fail.

6 Management and implementation

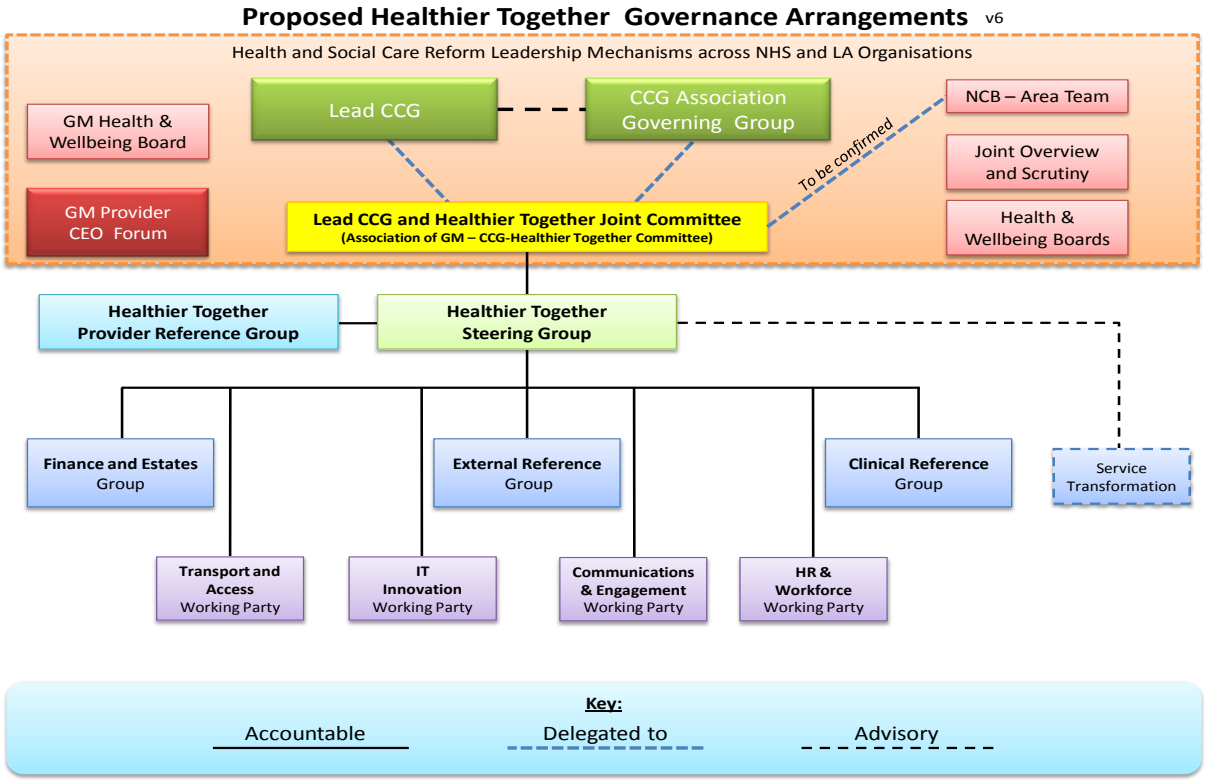
6.1 Future governance and decision making arrangements

6.1.1 The Large Scale Change Board was established in August 2012 to ensure rigour and coherence was applied to the totality of the new NHS Greater Manchester portfolio of Service Transformation programmes. This board was accountable directly to the Clinical Strategy Board (CSB). The CSB will cease to exist in its current form, from April 2013, from which time an Association of Greater Manchester CCGs will begin to operate.

6.1.2 From April 2013, both the Association of Greater Manchester CCGs and the National Commissioning Board Area Team will have responsibilities and accountabilities in ensuring the successful delivery of the Healthier Together programme. Therefore, it has been necessary to develop a mechanism which ensures both parties can discharge their responsibilities for the development of reconfiguration options that meet the requirements of the programme mandate and the needs of the health economy.

6.1.3 The future governance arrangements are outlined in the diagram below. As described earlier the importance of placing potential reform of hospital services in the context of wider health and social care reform locally and across Greater Manchester has been recognised. This will require joint leadership across the health and social care system in Greater Manchester, but such leadership does not form part of the formal governance structure for Healthier Together.

Figure 13: Proposed Healthier Together Governance Arrangements



6.2 Determining the options for consultation

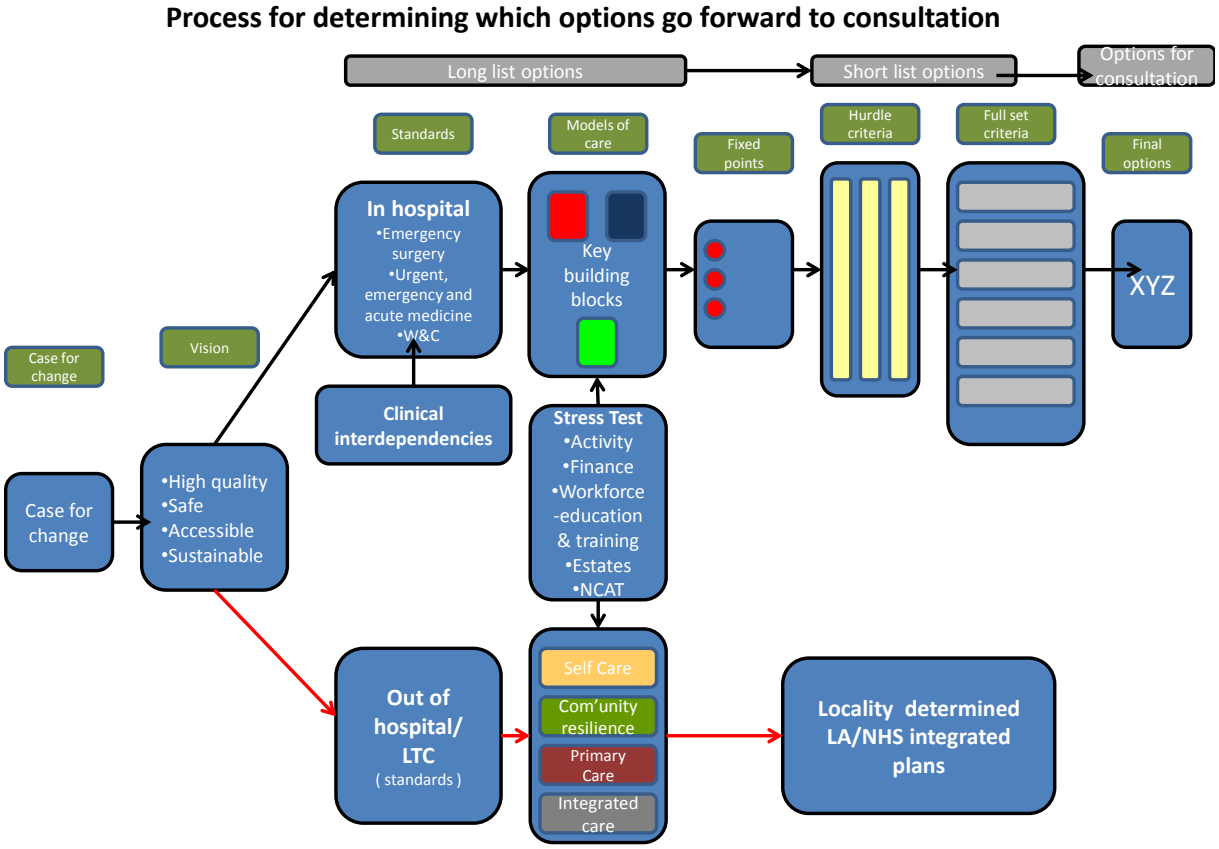
6.2.1 The process through which the outline model of care has been developed and the expected process for taking this through to options on which the public will be consulted on, is outlined in Figure 14. This involves testing out the outline model of care, determining the implications on activity, finance, travel, estates, and workforce etc, and developing a long list of options

6.2.2 The long list of options will then be appraised, initially by testing them against two 'gateways' which will immediately remove those options which do not acknowledge a set of agreed 'fixed points' and/or do not meet a set of agreed key (hurdle) criteria.

6.2.3 **Fixed points** are those sites/services within sites whose designation should be 'fixed' and which to change would result in a deterioration of services; and **Hurdle criteria** are a set of key or essential criteria that each option must be able to meet. The resulting short list is then put through an options appraisal using a full set of evaluation criteria.

6.2.4 The Clinical Reference Group and the External Reference Group will be pivotal to this process.

Figure 14: Process for selecting options for consultation with the public and stakeholders



6.3 The process for consultation

6.3.1 New regulations for public consultation come into force from April 2013, with the constitution of the lead CCG being the lead for the document, coupled with the existing statutory legal requirements as detailed in the Health and Social Care Act 2012, Section 14Z2 (Public Involvement & Consultation by Clinical Commissioning Groups) and supplemented with a range of additional Government guidance.

6.3.2 Additionally, a change in the landscape of statutory bodies will result in a double scrutiny arrangement including both Health and Wellbeing Boards and Overview and Scrutiny Committees during 2013-14. Notwithstanding these changes, the underlying obligation remains to operate a full, fair and honest consultation.

6.3.3 Given the scope and scale of the envisaged changes, we propose a model of Campaign, Outreach, Response, and Evaluation to ensure that a maximum number of affected people are aware of the consultation and that we gather rich responses which can substantially enhance the proposed transformation. The consultation approach will be structured into three key headings:

- Why is change necessary?
- How is change envisaged?
- What would the healthcare results be?

6.3.4 Risks to the public consultation lie primarily in the decision-making process leading up to it. Sufficient lead times must be allowed and it essential that the governance arrangements are robustly managed. The full Communications and Engagement Strategy is constructed to substantially manage the principal risks of the consultation process.

6.3.5 The main roles and responsibilities are outlined below:

- The consultor is the lead CCG on behalf of other CCGs and the Greater Manchester clinical community; and

- The consultees are the Affected Parties (general public, existing patients, affected staff, and affected organisations), their representatives (patient panels, voluntary organisations, delegated officers) and the Statutory Bodies.

6.3.6 A suite of methods for the Campaign, Outreach, Response and Evaluation is proposed at a scale to suit the population, nature of change envisaged, and cost/risk balance.

7 Next steps & timescales

7.1 The next steps in the Healthier Together Programme will be determined by the process and governance requirements outlined in section six. This section highlights those steps in the process that will determine the timescale for public consultation.

7.2 Development of Standards & Frameworks

7.2.1 **In-Hospital Care**

The Healthier Together programme has undertaken work on a broad range of health and care services. The programme initially focussed on the eight areas of care described in section 2.

7.2.2 Standards and models of care have been developed for in-hospital services - 'Emergency General Surgery' and 'Urgent, Emergency & Acute Medicine' and are under development for 'Women's and Children's services. These have informed the development of an 'outline model of in-hospital care' which when finalised will provide the building blocks for developing options for future hospital configuration in Greater Manchester.

7.2.3 The Clinical Reference Group which provides clinical leadership to the Healthier Together programme has suggested that additional standards will also need to be clinically agreed to inform the final 'model of in-hospital care' for other key specialties.

7.2.4 This advice needs to be considered by the Lead CCG & Healthier Together Joint Committee (April 2013) and a decision made on where additional standards are required and how service transformation will be taken forward for the other in-hospital areas originally covered by this programme e.g. Cardiac Imaging and Neurosciences.

7.2.5 It is expected that work on additional standards would be completed before the end of June 2013 after which stress testing and the development of options for future hospital configuration can be completed.

7.3 Integrated Care / Out of Hospital Care

7.3.1 It is clear that there is a significant amount of work to do to accelerate the further development of a Greater Manchester-wide view of integrated care across health and social care partners that supports and aligns to Local Integrated Care models. Some initial next steps are outlined in section 4.1.12.

7.4 Commitment to Resources

7.4.1 In putting forward any new proposals to deliver health and care, it is vital that the resource implications are clearly identified and agreed.

7.4.2 In particular major transformational change will need pump priming resources as services move from the "old way" to the "new way" in a phased and gradual way, there will need to be resources made available to make these changes safely. This will be undertaken as part of the detailed business case completed and agreed prior to any proposals being made or consulted on.

7.5 Timescales for Public Consultation

7.5.1 This paper has set out a compelling need for change and a clear vision describing how new, modern and improved services could be invested in by all public sector organisations to radically

improve the way we look after those suffering illness and injury and those most vulnerable to ill health in our society.

7.5.2 We have described a potential new model of that care which has been designed by both the clinicians that currently deliver care and the patients and carers who use services.

7.5.3 These proposals and how they might impact on residents, as well as on current organisations, need to be fully consulted on with all partners, stakeholders and interested groups particularly patients and carers.

7.5.4 Subject to the completion of the necessary process steps outlined within this document the aim remains to go out to public consultation on the future shape of health and care services in Greater Manchester later in 2013.

7.5.5 Clearly significant progress has been made on the development of an outline model of 'in-hospital' care and it is essential that the momentum gained within our clinical and wider community for system reform and change is maintained. Whilst that is the case, it must be acknowledged that the implementation of new governance arrangements and the critical requirement to ensure that 'integrated care' and 'out of hospital' services across the Greater Manchester wider system are at the core of the system reform will have an impact on the timescales for public consultation.

7.5.6 To balance these two competing tensions, during April and May 2013 Programme Managers will be developing plans to share detailed papers on:

- agreed standards of in-hospital care;
- the outline model of in-hospital care and potential building blocks for future hospital acute configuration with local acute hospital providers as part of the stress testing and due diligence work required to develop and assess options for future public consultation; and
- to continue to work with partners to describe and implement new models of integrated care locally at a pace and scale commensurate with the ambition to see a substantial reduction in avoidable admissions to hospital and care institutions.

7.5.7 This process, including rules of engagement, will need to be agreed by the Lead CCG & Healthier Together Joint Committee and will be subject to legal/professional advice and considerations regarding the management of the proposed public consultation process.

8 Conclusion

8.1 The NHS in Greater Manchester has served the public well for 65 years but we recognise that we are no longer fully meeting the needs of our patients, and that they deserve better. We are committed to working with all our stakeholders and partners to achieve the kind of transformational change needed to give everyone the excellent, compassionate care they would want for themselves; their families and their communities.

8.2 This document is the basis for further discussion with all partners. Over the coming months we will be developing a final model of care and the range of options that could deliver this before going out to public consultation later in the year.