Health and Social Care Reform
in Greater Manchester

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GM is a strong **functional economic area** with **coherent geographies** – ideal opportunity to prove concept at significant and replicable scale and link growth & dependency

- GM boundaries co-terminous with LEP, Police, Fire & Rescue, TfGM, Probation
- Generally consistent with NHS – GM plus part of High Peak
Our vision for Greater Manchester is that by 2020, the city region will have pioneered a new model for sustainable economic growth based around a more connected, talented and greener city region, where all our residents are able to contribute to and benefit from sustained prosperity and a good quality of life.
GM Public Service Reform - Overview

- GM has two priorities. Sustainable economic growth. And connecting people to that growth, so all benefit from sustained prosperity. This is set out in the GMS and our Growth and Reform Plan.

- This includes how we work with communities to change the relationship between public services and the public.

- GM is making good progress on growth and has been more resilient than most to the downturn. GM’s population will be larger & wealthier. It must also be healthier if public services are to be sustainable.

- However generating growth and jobs will not be sufficient to meet our ambition and top become a net contributor to the national economy:
  - GM spends around £4.5bn more than our total tax contribution
  - Total spend has not changed in real terms, but proportions have – more on welfare benefits: costs of failure (2008/09 – 2012/13)

- Big ticket proposals around reform to test at scale
  - Employment and Skills
  - Complex dependency to employment, and
  - Health and social care integration
Greater Manchester challenge

- Move away from being a cost to the nation and towards being a “net contributor”.
- We have to change the direction - start narrowing the gap.
- The investment framework for growth agreed in the GM Deal for Cities puts in place a system wide incentive on the growth side.
- The people side of the equation - more GM people getting more out of growth and, therefore, relying less on public services and lacks system wide incentive.
Long term worklessness has persisted through growth and recession

- Despite a range of programmes to tackle skills and worklessness issues, over 250,000 people are out of work across GM. Over half of are claiming ESA or IB
- WPL will test a more intensive, better integrated model of support for those who have been on the WP for 2 years and not found sustained work

Over 13 years, the ESA / IB cohort has stayed between 143,000 and 172,000
Fruit falling in other’s garden

Health and social Care
Costs:
Primarily hospital (wards) spend should reduce whilst community – based services (LA, NHS – funded) will increase

Key metrics:
• A & E Admissions

Benefits:
• Acute trusts ↓
• Community based spend ↑

Examples in our business cases

Troubled Families
Costs (c£18m, 1,000 families in 1 year):
Primarily local authority (more FIP workers) however seeking to broaden at next phase

Key metrics:
• Employment
• LAC
• Drug and alcohol dependency

Benefits:
• Benefits payments - £3.6m
• LAC - £4.0m
• Drug and Alcohol - £2.7m
• Other - £2.4m
• Total - £12.7m over 2y

For the shift to be sustainable, we need a mechanism to move money around the system... in the Greater Manchester case, Investment agreements
Public Service Reform – Principles & Application

Apply Consistent Principles

Integrate local services, ensuring the right support is available to the right people at the right time – tackling their specific barriers to work

Develop an evidence based approach, ensuring reform is based on an understanding of what works

Take a holistic based approach, recognising that barriers to work and the causes of poor mental health may lie beyond the individual

Integrate public services

- Bespoke packages of support will be developed, coordinated and drawing on appropriate local services and assets
- Alignment of resources across local partners to enable timely access to relevant services

Understand the benefits

Reduced worklessness
7% uplift on Work Programme performance (varies for different claimant groups)

Reduced drug dependency
50%

Reduced alcohol dependency
60%

Reduced mental health disorders
75%

Reduced tax credit payments through skills uplift
75%
Health and Social Care Reform

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Our Vision

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

#Bestcare
The Case for Change

- Healthier Together both started out and remained a clinically led programme to improve the outcomes and safety of patients across Greater Manchester.

- Healthier Together began with clinical engagement in April 2012, but it was Autumn 2013 before the Financial Case for Change was developed.

- The Financial Case for Change supports the Clinical Case for Change which underpins the Healthier Together Programme.

- Deloitte led the work across Greater Manchester commissioners and providers to identify the financial case for change.

- Separately information was also collected from Local Authorities to complete the financial challenge across Health and Social Care.

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£1.1bn Financial Challenge

- Scale of financial challenge galvanised working together as a GM economy
- Realisation transformational change implausible within individual organisations
- HT programme primarily clinically driven to improve patient safety & outcomes
- Would not deliver, by itself, a financially sustainable health and care economy
- Work started on what else would be required to close the financial gap
- HT website link [https://healthiertogethergm.nhs.uk/](https://healthiertogethergm.nhs.uk/)
A Single Programme with Multiple Governance

10 Local Health and Well Being Boards

10 models of integrated health and social care, with some GM wide commonality

Core Components of 3 Programmes
- Aligned programme gateways
- Common Engagement Timetable
- Patient/Public narrative
- Programme Support

Clinically led in-hospital redesign across GM
Urgent, Emergency and Acute Medicine
General Surgery
Women’s and Children’s

GM CCGs Committee in Common

Joint OSC

GM Integrated Care Programme

In Hospital Care Programme

GM Primary Care Programme

Primary Care Commissioning Strategy developed by NHS England working with CCGs, AGMA and others

NHS England
Our System Agreement – 22nd Feb 2013

“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.
- This may change what services are provided in some local hospitals, but no hospital sites will close”

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In Hospital Programme

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Here and Now...Healthier Together

A once in a lifetime opportunity to transform outcomes for GM people from Hospital Services

Mortality of patients who undergo Emergency General Surgery varies from 23.1 to 51.7 per 1,000 spells across GM.

280 avoidable deaths per year in GM.

GM Quality and Safety Standards Audit

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In Hospital - In Scope

• Urgent and Emergency Medicine
• Acute Medicine
• General Surgery
• Children’s Services
• Women’s Services
What has happened so far?

Developed by:

- **62** clinical congresses in UEAM, General Surgery, Women’s, Children’s, Anaesthetics & Critical Care, Diagnostics & Therapies & Pharmacy
- **410** senior clinical and social care leaders
- **78** organisations across GM

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NCAT’s recommendation

“The unanimous opinion of the NCAT panel is to strongly support the programme and to give clinical assurance that the programme can proceed to public consultation”.

“It is the panel’s opinion the programme offers an approach and modelling that is an exemplar for the NHS and its partners as they grapple with improving safety, value and sustainability in financially more austere times”.

The panel were impressed by the:

• Programme’s ambition, vision and scope
• Impressive public and clinical engagement
• Commitment by Local Authorities, Health and Wellbeing Boards and NHS Organisations

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Single Service

Local services
- 24/7 A&E
- Children’s Short Stay Assessment Unit
- Low volume critical care
- Low risk elective surgery
- Acute Medicine

Specialist services
Local services plus:
- 24/7 A&E – Highest acuity cases
- High volume critical care
- High risk General Surgery
- Acute medicine
Optional:
- Major Trauma
- Obstetric-led Maternity Unit
- Children’s Inpatients
- Children’s Observation & Assessment Unit
- Neonatal Intensive Care
Community Based Care Programme

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GM Integrated Care Programme

- Jointly led by each Clinical Commissioning Group and Local Authority

- New Community Based Care standards
- New Service Models,
- And the associated and necessary activity and financial shift,
- Part of the public conversation and engagement process on whole system reform (commenced January 2014)
- Support to 10 sites and their models to overcome the challenges:
  - Models of Contracting and Reimbursement
  - Competition and Collaboration
  - Workforce
  - Information sharing and new technology deployment
- 10 models of integrated care in shadow operation by 1\textsuperscript{st} April 2014 and in full operation, backed by the HM Treasury approved CBA by 1\textsuperscript{st} April 2015.
### Framework for Integrated Care Development

| Collaboration & Partnerships | • Built on a **whole systems vision** and the product of genuine co-production  
• Spreads personalisation and makes the **best use of community assets** |
| Commissioning, information and governance | • **Reallocates resources across the system** to secure early intervention & prevention  
• Sits as part of a strategy which **responds to the total economic challenge**  
• Establishes and **pools resource** according to the model of care  
• Confirms a clear **contracting, pricing & incentives methodology** to support the model of care  
• **Enables information flows** across the system to support care planning, care delivery, payment and performance monitoring |
| Population, Impact & Evidence | • Has **agreed whole systems outcomes** to be delivered  
• Has **segmented the population** according to a broadly based risk stratification process  
• Has an **agreed evaluation methodology** for the community based model  
• Can **confirm the population currently supported** and engaged through the model of care  
• Can provide a description of impact against **agreed monitoring metrics** |
| The Model of Care | • Has established **multi-disciplinary teams** at the neighbourhood level bringing all relevant providers together on the basis of the GP’s registered population. The Teams provide:  
  ✓ **An individual care plan** for each patient identified  
  ✓ **A named accountable professional** for each patient  
• Has agreed the process and timescale for **full borough coverage**  
• Is progressing **a plan for workforce development** which will secure immediate and ongoing sustainability for the model of care |
Primary Care
Here and Now...Primary care Transformation

**Long term condition management**
- Identification
- Condition management
- Medicine Optimisation
- Integrated Care Teams

**Involvement in Care**
- Access to care records
- Promotion of self-care
- Primary prevention
- Patients die in place of their choosing

**Access and Responsiveness**
- Easy appointment booking
- Range of contact mediums
- Continuity of Care
- Increased responsiveness of primary care services
- GP is co-ordinator of care

**Specialist primary care services**
- Smooth primary/secondary care interface
- Locality based enhanced services
- Inter practice referrals

**Quality & Safety**

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The Primary Care transformation programme is now in its implementation phase

• The Primary Care strategy was formally adopted in January 2014 (following a period of extensive engagement with various stakeholders across GM)

• The Primary Care Transformation programme now initiated to facilitate the implementation of the strategy. The programme will:
  - Support the GM localities and NHS England in developing and implementing innovative models for delivering services in Primary Care.
  - Ensure all the enabling infrastructure for implementing the Primary Care strategy are developed and operational
  - Liaise with all relevant Health and Social care reform programmes and stakeholder groups to ensure interdependencies are clarified and managed.

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Progress continues to be made in a number of key areas

- Demonstrator sites continue to make significant progress (currently covering a population of 377 000)
- Plans underway to secure additional funding to increase the number of sites and coverage across GM
- Innovative provider models starting to emerge
- Localities have started to implement programmes to improve Access to primary care. For example, in Central Manchester:
  - 3 out of 4 localities are now open to see patients up to 8pm during the week and for three hours Saturday & Sunday. This will soon extend to include all registered patients in Central Manchester
  - 95% of Central Manchester registered patients are with practices who have agreed to see patients on the same day if they need it.