



# Improving Health in Manchester

Commissioning Strategic Plan **2009-2014**

# Contents

1	Foreword .....	1
	Executive Summary .....	3
2	Vision, Priorities and Values .....	6
3	Context .....	9
3.1	Policy, national priorities and strategy. ....	9
3.2	Where are we now? Population health needs .....	12
3.3	Where are we now? Partnerships. ....	18
3.4	Where are we now? Our healthcare providers. ....	22
3.5	Where are we now? Resources .....	24
3.6	Where are we now? Overall Performance. ....	28
3.7	Our Organisational Capacity and Capability. ....	29
4	Strategy .....	31
4.1	Developing our Commissioning Strategic Plan. ....	31
4.2	Goals and metrics. ....	33
4.3	Strategic Initiatives: to deliver goals .....	36
4.4	Summary of Overall Impact .....	43
4.5	Affordability .....	49
5	Delivery .....	53
5.1	The Operational Plan .....	53
5.2	The Operational Development Plan .....	53
5.3	Key Themes for Delivery. ....	57
6	Board Approval .....	59
	Appendix 1 .....	60
	Appendix 2 .....	62
	Appendix 3 .....	64
	Appendix 4 .....	66
	Glossary of Terms. ....	109



# 1 Foreword

Manchester is proud to be one of the most dynamic and diverse cities in the United Kingdom. It has come a long way since its origins at the heart of the industrial revolution 150 years ago. In its 21st century guise it continues to grow as a centre for commerce and prosperity, with a new focus on green and knowledge-based developments, and is widely regarded as the nation's second city. But while life expectancy has improved significantly even in the last decade, people's health and wellbeing have not prospered fully in Manchester's transformation. High rates of smoking, drinking and poor diet have been key factors in a cycle of ill health that compares unfavourably to other major cities. Now high numbers of overweight children and teenage pregnancies add to the evidence that this pattern will continue without a concerted effort to achieve better health. This commissioning strategic plan is our approach to changing this cycle.

NHS Manchester is ambitious and we recognise our role in enabling residents to enjoy life to the full. Put simply, our task is one of the most fundamental of all in modern Manchester: we're here to help local people lead longer and healthier lives.

The scale of this challenge is considerable. Men have the shortest life expectancy of any in England, and women the fourth lowest. Behind these stark facts is the every day reality

of the poor physical and mental health experienced by many people in Manchester. It is time to change this for the better. By directing local investment in the National Health Service where it is needed most, with the support of our partners – including the wider NHS, Manchester City Council, practice based commissioners, the statutory and voluntary sectors and, most importantly, local communities through effective engagement in their health and health services - we believe we can make a real difference.

Over the next five years we will focus on a number of specific priorities to achieve these improvements. We aim to increase life expectancy overall and make the greatest strides forward in areas where health is currently poorest. We will tackle Manchester's high rates of alcohol consumption, childhood obesity and teenage pregnancy, and provide better support for people who have long term health problems. Raising the quality of care provided by the local NHS and making it easier to get advice or treatment from a health professional will also be top priorities.

This plan explains how we intend to address these issues over the next five years. Manchester's journey to a happier, healthier and wealthier city is well underway and we are proud to be playing our part – we hope you will be too.



**Laura Roberts**  
Chief Executive



**Evelyn Asante-Mensah OBE**  
Chair

# Professional Executive Committee Chair's Foreword

**I am very pleased to contribute to the Commissioning Strategic Plan and well aware of the heavy responsibility that we share with colleagues throughout NHS Manchester. As a working general practitioner, the undeniable fact that the population of such a commercially and academically prosperous city should have much of the worst health in the United Kingdom remains a constant reminder that there is a great deal of work to do to make Manchester a healthy environment with healthy people. While the development of changed organisations and policies within the NHS has undoubtedly presented us with challenges, I firmly believe we are now both structurally and functionally better equipped to face the future than at any time in the past.**

Effective partnership between managers and clinicians is crucial to the commissioning of innovative, effective and safe services and this needs to be reflected at every level within the organisation. At Executive Management Team, I contribute on a weekly basis and such effective partnerships exist within each of Manchester's three Practice Based Commissioning (PBC) hubs.

The development of PBC here has been more rapid than in many other areas and demonstrates not only effective clinical engagement but clinical empowerment backed by imaginative and supportive management colleagues within NHS Manchester. The involvement of clinicians through PBC is key to ensuring that health care services are effective at meeting need, delivered close to home and tackling the highest priority health needs including better support for people with long term conditions.

Having reflected on the achievements led and realised by PBC over the past two years, the hubs and NHS Manchester have agreed a set of strategic targets for service improvement, outcome improvement and productivity release over the course of this 5 year plan, with specific initiatives identified for 2008-9 and trajectories beyond. These initiatives and trajectories are described in the plan. Meanwhile an accountability framework outlines the contribution of PBC to

delivery on these targets, together with the governance and delegation arrangements to enable each hub to be held to account.

Within the Professional Executive Committee (PEC), members provide a forum that evaluates business cases from both a multi-professional and 'real world' perspective and can act as a flexible clinical engagement resource for NHS Manchester. Our membership includes social workers and a range of health professionals, with the option to co-opt members where additional knowledge or skills are required. Forthcoming priorities will include working on the Manchester Standard described later in this plan, to set a clear benchmark and raise standards in primary care, and the development of a new Primary and Community Care Strategy for Manchester.

Clinical engagement also extends well beyond the structures of PEC and PBC. Chairs from each PBC hub are among those who contributed to the debate and dialogue of the Improving Health in Manchester programme, which has strongly influenced new investment during 2008-09 and the development of this plan. Clinicians from Manchester have been involved in commissioning services across Greater Manchester, particularly the development of a new, leading edge stroke service. Many more continue to be involved in redesigning clinical pathways and contributing to assurance and governance processes relating to service reconfigurations taking place across north Manchester and surrounding areas. Meanwhile clinicians have been engaged in working with neighbouring and partner organisations, crucial in such a tightly knitted conurbation.

The challenges we face are considerable but as NHS Manchester continues its rapid progress we firmly believe that as a community we will have the skills, knowledge and enthusiasm to be successful.

**Dr Liam McGrogan**

Chair, Professional Executive Committee



# Executive Summary

**This is NHS Manchester's first commissioning strategic plan, a document that we hope you will find both compelling in its ambition to improve health in Manchester and clear in its description of how we intend to get there. Our city has come along way since its origins at the heart of the industrial revolution; now widely regarded as England's 'second city' and with a growing track record of impressive regeneration and inward investment. People's health, however, has not enjoyed the same transformation as the city's skyline. With the shortest life expectancy for men anywhere in England, and the fourth lowest for women, poor physical and mental health wellbeing are a daily reality for too many local people. Imagine a Manchester where our communities' health can make the same great strides forward as the city itself.**

*Our vision is to address the most fundamental of inequalities by improving health in Manchester.*

The commissioning strategic plan describes how NHS Manchester will aim to realise this vision over the next five years. While we are well placed to lead this work on behalf of the NHS and on behalf of everyone who lives in the city, this is not something we can achieve alone.

Our strategic commissioning partners, most notably Manchester City Council and local GPs through practice based commissioning, have played a valuable role in the development of this plan and will share our interest and leadership in its implementation. Our partnerships with providers of NHS services and the third sector will be increasingly important as we seek to offer new solutions, better access, choice and more care closer to home. Meanwhile we intend to establish a new relationship with patients and the general public so that their voices are clearly heard and taken account of in the planning of health services.

The views of organisations and representatives with an interest in improving health have contributed to the

development of this plan in a number of ways. Its origins are closely linked to the Improving Health in Manchester programme, which we initiated in autumn 2007 to give stakeholders a meaningful role in directing local NHS funds to those health issues and evidence based initiatives that could achieve the greatest benefit to public health. At the same time, Lord Darzi's national report High Quality Care For All and NHS North West's regional vision Healthier Horizons were under development in collaboration with clinicians, patients and the public.

The outcome of these processes has been to lay down a marker for the future of Manchester's NHS, where advice and treatment are centred on each individual's needs, appropriate services are readily available, safe and of the highest quality, and everyone is empowered to enjoy a longer, healthier life.

## Our Objectives

To improve health in Manchester we have identified three main objectives:

- We will tackle health inequalities and improve aspiration and wellbeing;
- We will make sure health services are safe; and
- We will commission services that are accessible and personalised.

We have also recognised a fourth area for development that will enable us to deliver this plan effectively; the need to develop our people and improve our systems. A summary of our objectives and priorities is illustrated in figure 1.



## Our Priorities

By identifying clear priorities we are seeking to create a strategic focus on those areas where a concerted effort will achieve the greatest gain for local people's health. The ten priorities we have identified are to:

- Help people to live longer;
- Reduce the gap in health between different communities;
- Reduce the number of teenage conceptions;
- Reduce the number of alcohol-related hospital admissions;
- Reduce the number of children who are overweight;
- Make sure health services are safe;
- Improve the quality and availability of primary care services;
- Make sure patients with a long term condition have a personalised care plan;
- Improve access to planned care; and
- Improve access to urgent care.

## Strategic Initiatives

To detail our approach to addressing these ten priorities we have set out a Strategic Initiative for each, encompassing the main programmes of work that will deliver the improvements we are striving for. Mental health is a core element of our vision and a key theme addressed within a number of the Strategic Initiatives. To provide a clear overview and focus for the improvements we aim to achieve, we have created an eleventh Strategic Initiative for improving mental health. Each Strategic Initiative includes a clearly defined and measurable outcome, a baseline position and milestones to be achieved by 2010 (in keeping with the Local Area Agreement), 2013 and 2015.

The financial impact of these Strategic Initiatives is a fundamental aspect of delivering our vision, explained in more detail in our separate Financial Plan. Our planning is based on the need to ensure the Strategic Initiatives are affordable and sustainable over the next five years. Accordingly we have made a number of assumptions including that the starting point is for all new investment to be drawn from savings within the local NHS. Above all we

recognise that to achieve the desired outcomes there must be an overall shift in resources, with a greater proportion of NHS funds supporting primary care and interventions that will improve prevention and early detection of illness.

## Delivery

The implementation of this plan will now become NHS Manchester's first priority as a commissioner. The changes it describes aim to transform health and health services; delivering it successfully will be a considerable challenge. Programme management will be used to coordinate our approach, ensuring risks are managed and the benefits of the Strategic Initiatives are fully realised. There will be a crucial role for practice based commissioning as a focus for developing clinically-driven services that maximise the quality and accessibility of NHS care. We will embed the engagement of patients, the public and other stakeholders in our commissioning processes. Our commitment to equality and diversity will demand that services are developed to support better healthcare and better health for all of our communities.

Two key documents will underpin the implementation of the plan. The Operational Plan will set out our arrangements for delivering the eleven strategic initiatives. It will be developed in partnership with our stakeholders and describe clearly our planned actions, which will be reviewed on an annual basis. Accordingly, the second key document is the Organisational Development Plan, which will enable us to develop as an organisation able to deliver the required changes. This will provide the basis to align the activities of our commissioning functions to our objectives, to reshape our structures and processes to meet the needs of the plan and to build our people's commitment, skills and capabilities for achieving world class commissioning.

The plan presents a challenge to us, our commissioning partners and service providers alike. We hope that you find it a useful guide to our priorities and intentions for the future and agree that it represents a rare opportunity to transform health in Manchester for the better.



Figure 1 - Summary of our vision, objectives and priorities

VISION	Improving Health in Manchester			
OBJECTIVES	Inequalities, aspiration and wellbeing	Safe and effective services	Accessible personalised services	Developing our people and systems
PRIORITIES	<ol style="list-style-type: none"> <li>1. Life expectancy</li> <li>2. Health inequalities</li> <li>3. Under-18 conceptions</li> <li>4. Alcohol related admissions</li> <li>5. Childhood obesity</li> </ol>	<ol style="list-style-type: none"> <li>6. Reducing avoidable harm from healthcare</li> <li>7. High quality primary care</li> </ol>	<ol style="list-style-type: none"> <li>8. Personal Care Plans</li> <li>9. Reducing waits, access to planned care</li> <li>10. Access to urgent care</li> </ol>	Addressed by Organisational Development Plan
	<p><i>I will be living a healthier lifestyle (4)</i></p> <p><i>My family will have a better opportunity to live a longer healthier life (5)</i></p>	<p><i>I will be receiving higher quality clinical care (3)</i></p> <p><i>I will be receiving more integrated seamless care, when I need to get help from more than one organisation (7)</i></p> <p><i>I will be receiving the best technologies as part of my care (9)</i></p>	<p><i>I will be more involved in decisions made by the NHS (1)</i></p> <p><i>I will be receiving better customer care and an improved patient experience (2)</i></p> <p><i>I will be receiving more personalised care (6)</i></p> <p><i>I will be able to receive more of my care closer to my home (8)</i></p>	<p><i>My NHS will be maintaining a healthy financial position (10)</i></p>

### 'Healthier Horizons for the North West' Touchstone Tests

Local Area Agreement

Vital Signs

World Class Commissioning Data Packs

# 2 Vision, Priorities and Values

**We aspire to a modern Manchester whose economic growth and increasing prosperity extends to better health and wellbeing for all its communities. There must be a focus on tackling the most common major diseases, such as heart disease and cancer, with excellent healthcare for those who are ill. Moreover there must be a united effort to prevent illness and improve health; a task that the recent report of the World Health Organisation's Commission on the Social Determinants of Health confirms is far beyond the reach of health services alone.**

## Our vision is Improving Health in Manchester.

This vision reflects not only the ambitions of our Board, Professional Executive Committee and staff but also those of the many others who share our aspirations for a healthier city, including Manchester City Council, clinicians and a range of other organisations and individuals. We know this because we have worked hard to form strong partnerships that help us to identify and act on our priorities,

'Improving Health in Manchester' was originally the name given to a groundbreaking engagement programme that involved these stakeholders in identifying how and where to concentrate investment through our most recent local delivery plan. Beginning in summer 2007, it was a new and innovative approach to agreeing how investment by the NHS could make the biggest difference to people's health. As a result a series of proposals were developed and these strongly influenced our new investment in the current year, with growth monies identified to invest in a range of initiatives from 2008-09 onwards.

The programme highlighted, explored and gave a firm financial commitment to a common sense of purpose that will add life to years and years to life. This, together with the simple resonance of the name given to the programme, led us to the view that the term Improving Health in Manchester can serve as a compelling, overarching vision for NHS Manchester.

To achieve the improvements we aspire to, the scope of this plan goes beyond any organisational boundaries. Its implementation will be led by NHS Manchester and driven

through effective partnerships, but we need to go further and make health an important issue in the lives of local people. We must show individuals and families that better health and wellbeing are within reach. Having instilled this ambition we have to make sure they have the opportunities and support they need to get there.

This will require a new relationship to be formed with patients and the public. It must be a relationship that puts the needs and preferences of local people at the heart of our decision making, guiding further improvements in the quality and access of NHS care and empowering individuals to achieve better health. The Talking Health programme, launched in 2008, signals our intent to develop such a relationship, having established a common brand for conversation between NHS Manchester, the public and other stakeholders. It has gained an increasingly high profile and provides a strong basis for establishing NHS Manchester as an organisation that engages in meaningful, ongoing dialogue rather than piecemeal consultation.

## Towards World Class Commissioning

The World Class Commissioning programme offers an opportunity to transform the way NHS services are commissioned, with a more strategic and long term approach and a clear focus on improved health outcomes. This plan describes how we aim to achieve the gains world class commissioning can offer to everyone in Manchester. It is the first time we have set out our plans in this way and should be of interest to service providers, partner organisations and others who have a role to play in making the city a healthier place to be.

We have identified our overarching strategic objectives for future commissioning. These are that:

- we will tackle health inequalities and improve aspiration and wellbeing;
- we will ensure safe, effective services; and
- we will commission accessible, personalised services.

Aligned to these strategic objectives we have identified ten priorities, each with an accompanying strategic initiative, that we believe will have the greatest impact in improving





physical and mental health and wellbeing. Additionally we have agreed an eleventh strategic initiative to provide a clear overview and focus for the improvements in mental health that are embedded in the ten priorities. The strategic initiatives further develop the themes of preventing illness and providing fast access to high quality care. Each has a specific and measurable goal and builds on the vision set out in Lord Darzi's recent national report High Quality Care for All and NHS North West's Healthier Horizons for the North West.

Considerable work has been undertaken to establish the evidence base both for the efficacy of the measures planned and the cost and savings profiles relating to each of the strategic initiatives. However, implementation of these initiatives will not be sufficient in themselves to keep us in recurring financial balance. In implementing these initiatives we therefore recognise that the changing strategic environment will require wide-ranging system reform, including an overall shift in the use of NHS resources, supported by increasingly robust financial mechanisms, to ensure a sustainable future. For service providers this will create challenges and new opportunities to improve care and quality of life for patients.

In order to help us to deliver this plan we will also need to develop our people and improve our systems. We will adopt a programme management approach to coordinate the delivery of the strategic initiatives, managing risks and ensuring the benefits are fully realised. The input of practice based commissioners will enable service developments to be driven by clinicians to achieve the highest quality and accessibility for patients. The fundamental roles of both stakeholder engagement and striving for equality in health and opportunity for our diverse communities will be firmly embedded in our commissioning processes, to ensure the local NHS is responsive to people's needs.

## Our Priorities

The health challenges in Manchester are significant and complex. The process of establishing the priorities for our commissioning strategic plan has been robust and rigorous. It has taken account of the following: the views of our Board, clinicians and senior managers, our partners and other stakeholders, the preferences of patients and the public, and national, local and regional priorities described in the Local Area Agreement (LAA) and Joint Strategic Needs Assessment (JSNA). In addition, a Multi-Criteria Analysis Tool (MCA) has been developed to support the prioritisation of

investments across NHS Manchester's business processes, incorporating criteria and weightings that were first applied to rank proposals emerging from the Improving Health in Manchester programme. These criteria are as follows:

- Reducing health inequalities
- Health gain
- Improving access to services
- Improving care process
- Achievability
- Sustainability

We have also used a number of other methodologies to support the prioritisation process, including:

- A multi-factoral assessment of needs at ward level, which supports future investment decisions
- Programme budgeting

There are numerous issues that sit outside our chosen ten priorities, where we will continue to strive to deliver better health and service outcomes. However, by identifying clear priorities we are seeking to create a strategic focus on those areas where a concerted effort will achieve the greatest gain for local people's health. The ten priorities we have identified and the rationale for their selection are highlighted in Figure 1.

## Our Values

In delivering this vision and objectives we are committed to a set of values which were agreed by the Board when the organisation was formed in 2006. Our approach will be:

### Open:

- Get out and about, be visible and accessible to community groups, the public and patients;
- Make sure that roles and functions are clear;
- Use plain language people can understand;
- Listen to staff, patients, and the public and provide feedback; and
- Have transparent decision-making.

### Fair:

- Treat all staff fairly and be seen to do so;
- Listen to the full range of views before coming to conclusions and decisions;
- Make tough decisions when needed.



**Respectful:**

- Treat each other as we would wish ourselves and our families to be treated;
- Achieve the standards we would expect for ourselves and our families; and
- Value and utilise diversity in the workforce.

**Ambitious:**

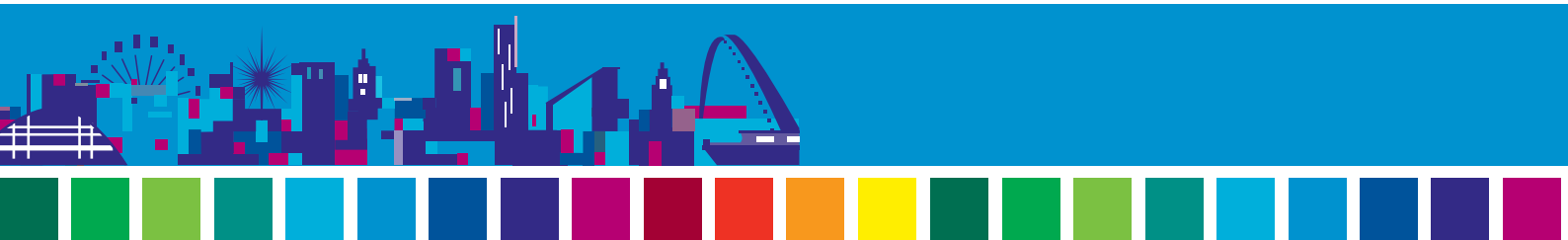
- Set clear and ambitious goals for ourselves, our teams and the organisation;
- Maintain a clear drive towards our goals; and
- Support staff to excel in their fields of responsibility.

**Challenging:**

- Challenge discrimination in all its forms;
- Challenge poor practice and poor quality; and
- Lead by example.

**Accountable:**

- Do what we say we will;
- Take leadership responsibility;
- Be accountable to the public and stakeholders for delivering on our goals; and
- Be accountable for our individual performance, our personal development and our behaviour.



# 3 Context

**NHS Manchester is responsible for the direction, purpose and capacity of local health services and is the lead public body for improving the health of Manchester people. In order to deliver these responsibilities we are able to draw on considerable financial resources, the services of a wide range of provider organisations and partnerships with other organisations that can assist us in meeting our wider responsibilities.**

**However, while available resources are significant in scale they are not limitless and we must use them carefully and effectively to benefit a population with some of the highest levels of health need in England. This section describes the operating environment in which we seek to deliver our vision for better health.**

Firstly, it explores the national and regional strategic context that has been central to the development of this plan, in particular Lord Darzi's national report High Quality Care for All and NHS North West's regional vision Healthier Horizons for the North West. The role of clinicians and the public in developing both of these valuable documents is important to us and, along with our local engagement activities, has helped to ensure our plan is evidence-based and consistent with people's expectations and aspirations for health and healthcare.

Next we describe the complex health profile of our city. While the overall picture of improvement in our communities' health in recent years is encouraging, the fact remains that public health in Manchester is acutely challenged when compared with most other parts of the country. Demographic change including a significant anticipated increase in the number of residents living here over the next decade will bring many benefits to the city but also requires a detailed understanding of how it will change and impact on demand for healthcare.

The third theme examined in this section is that of partnerships. We cannot achieve this plan alone so the roles, strategies and perspectives of our key partners are vital. At a strategic commissioning level our most fundamental relationships will be with Manchester City Council and our three practice based commissioning hubs in north, central

and south Manchester. Our relationships with service providers must offer new challenges while maintaining effective partnerships towards shared goals. Our approach to engaging with patients, the public and communities of interest through Talking Health must overcome the barriers that may traditionally have limited people's ability to engage with the NHS.

Fourthly we discuss the range of providers we commission from and how this is anticipated to develop in future, summarising our strengths and challenges in the marketplace. Our ability to influence this aspect of the operating environment through effective contracting and performance management will be key to raising the quality and safety of care received by patients.

Next we explore our position and forecasts for available resources. Currently we have a sound overall financial position but must plan for anticipated reductions in the growth of funding from central government and ensure our outcomes fully reflect levels of investment.

The section concludes with an overview of our performance against key national and local targets and requirements and, finally, an analysis of our capacity and capability requirements and plans, which are set out in full in our separate Organisational Development Plan.

## 3.1 Policy, national priorities and strategy

During 2008, the NHS celebrated its 60th anniversary. While the core principles of the NHS remain largely unchanged, its focus and overall strategy are changing significantly. NHS North West, the region's strategic health authority, has recently undertaken a comprehensive engagement process to explore the future roles of the NHS within our society. The exercise was conducted with patients, the public and clinicians and suggested the following long term trends:

- the public will expect increasingly personalised services;
- patients and the public will expect more control over their care and the environment in which it is delivered;
- there will be growing, active support towards prevention and prediction of ill health;



- there will be an expectation of quality and emphasis on outcomes, irrespective of how and where care is provided;
- the importance of harnessing advances in technology will grow to support and enable all of the above; and
- there will be emerging questions about the extent to which individual and community preferences could dramatically influence the shape, scope and philosophy of service provision.

On the basis of these trends, NHS North West identified four possible scenarios for the future of the NHS in the region. These scenarios are summarised in figure 2.

This commissioning strategic plan makes an important local contribution to the scenarios proposed above. NHS Manchester, like the wider NHS around it, is shifting its focus towards an alliance with the public and with other public, private and voluntary bodies to reduce disease and ill health and to promote and enhance good health and longevity. This means that the traditional emphasis on hospital based services will continue to be reduced in favour of primary and community services. It also means that the traditional emphasis on health care interventions and treatment will be increasingly balanced by an emphasis on disease prevention and health promotion.

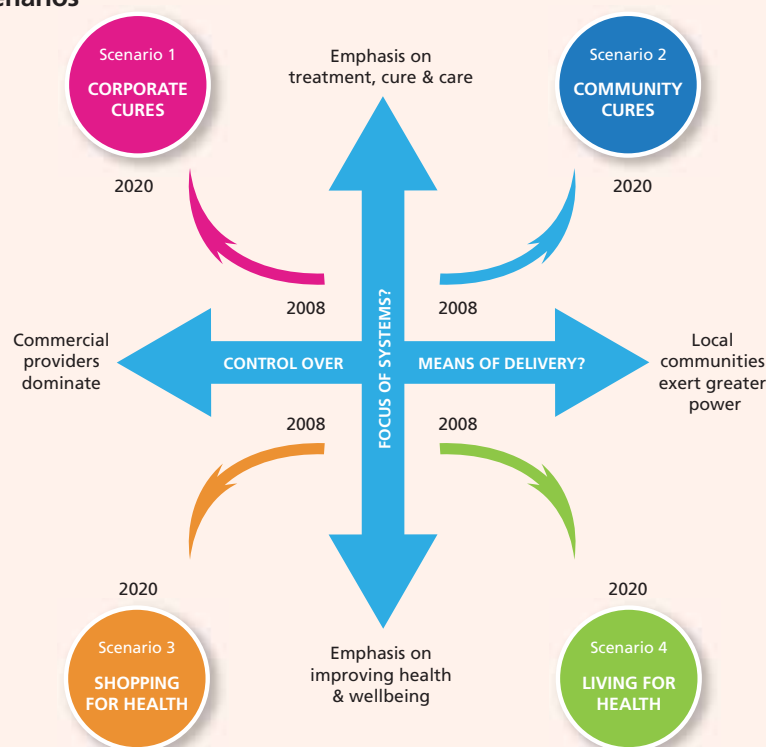
This change in emphasis is accompanied by another major shift in the NHS vision of health and healthcare. This vision is one where the patient, as a consumer, expects to receive healthcare services in the same ways that many other consumer services are experienced, whether they are purchased through private or public money. In this vision, healthcare is personalised, convenient, flexible and of the highest possible quality and safety. It is healthcare for a 21st century consumer society.

### 3.1.1 Lord Darzi's Review of the NHS

The future of the NHS has most recently been described at national level in Lord Ara Darzi's report entitled High Quality Care For All. Lord Darzi sets out a far reaching programme for the NHS:

- Every primary care trust to commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered being personalised to meet the specific needs of individuals;
- A Coalition for Better Health, with a set of new voluntary agreements between the Government, private and third sector organisations on actions to improve health outcomes;

**Figure 2 - Strategic Scenarios**



- Raised awareness of vascular risk assessment through a new 'Reduce Your Risk' campaign;
- Support for people to stay healthy at work;
- Support for GPs to help individuals and their families stay healthy;
- Extension of choice of GP practice;
- Development of a personalised care plan for everyone with a long-term health problem; and
- Guaranteed access for patients to the most clinically and cost effective drugs and treatments.

Implementing this vision has major implications for everyone in Manchester; not just the NHS but also its partners and individual citizens.

### 3.1.2 The Future NHS: individuals and the community

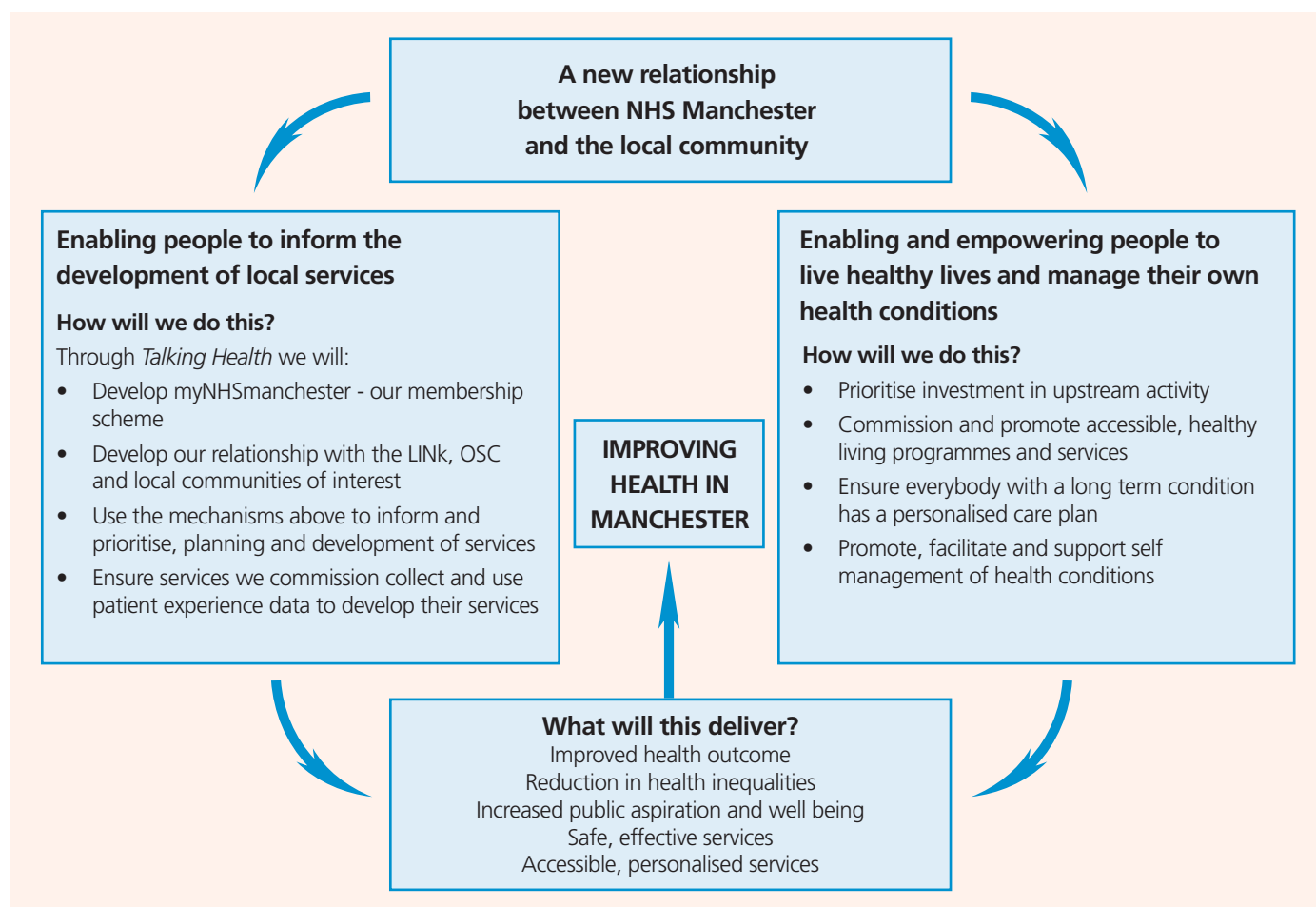
NHS Manchester, like the NHS as a whole, is entering into a new kind of relationship with the public. This new

relationship is about enabling and engaging patients and the public more effectively.

**Enabling** people to take more control over their health. For example reducing smoking, drinking alcohol more sensibly, increasing levels of exercise and eating healthier, are important lifestyle changes individuals can make to improve their own health. NHS-led interventions can make a valuable contribution to empowering individuals to make these changes, but more fundamentally it is by working with partners, particularly in local government and regional bodies such as North West Development Agency and the Learning and Skills Council, that we can help develop healthy, sustainable environments and communities with more jobs and wealth creation for a healthier Manchester.

**Engaging** people to become more involved in their local NHS organisations. The NHS will listen and increase the direct role that people can play in shaping the NHS and the decisions it takes on investing taxpayers' money.

This new relationship and how we are planning to get there can be summarised by figure 3:





## 3.2 Where are we now?

### Population health needs

Manchester is one of Europe's major cities and an engine of economic growth and prosperity for the region. Its city centre has undergone award-winning regeneration and the benefits are beginning to show in other areas. However, as has already been noted, it continues to face considerable health inequalities and major social, economic and environmental challenges.

This section contains an overview of the city's population, its health needs and a description of the current position in relation to the priorities that are the focus of this plan. The needs assessment information is primarily drawn from the Manchester Joint Strategic Needs Assessment (JSNA) but also incorporates data previously used as part of:

- NHS Manchester Operational Plan 2008/09 - 2010/11;
- Manchester Local Area Agreement (LAA) 2008/09 - 2010/11; and
- State of the City and State of the Wards reports 2008.

The section also includes data from the latest version of the national Health Inequalities Intervention Tool.

#### 3.2.1 Local Demographic Trends

**Growing population:** Over the next 10 years, the population of Manchester is projected to increase by 15.4% (from 458,100 in 2007 to 526,800 by 2016). The male population is growing at a faster rate than that of females.

The numbers of children aged 0-14 and adults of working age are both projected to increase. Overall, the population of older people is also projected to grow, with the greatest increases occurring in the 65-74 and 85+ age groups. The population aged between 75 – 84 is projected to fall slightly in the period up to 2012 but will then start to grow again.

Population growth in Manchester is being driven by a rising birth rate and increasing levels of international migration. Between 2006 and 2016, the number of births is projected to increase by 20.5% and the number of people moving into the city from areas outside of England and Wales by 8.6%.

**Increasing ethnic diversity:** The proportion of the

population from a non-white ethnic group is projected to increase by 21.6% by 2011 and by 39.6% by 2015.

More recently the black and minority ethnic population in Manchester is estimated to have grown from 25.6% of the population in 2001 to 29.0% in 2005, an increase of 19.2%. The largest increases during this period were for Black African, Chinese and Other White groups. These changes reflect the growth in inward migration from European Union Accession States and certain African countries such as Nigeria. The figures indicate that international migration is likely to have a bigger future impact on health needs in the city of Manchester than internal migration within the city and from other parts of England and Wales.

**Higher unemployment:** Manchester's unemployment rate stands at 3.7%, compared to the UK average of 2.3%. The highest rates are in north and east Manchester, the areas south of the city centre and in parts of Wythenshawe.

9.4% of economically active people aged 16-19 years are claiming unemployment benefits, compared with 7.2% in the North West as a whole. Young unemployed people currently account for around 9.4% of all unemployed people of working age.

**Higher incapacity benefit claimants:** 60.4% of Incapacity Benefit/Severe Disablement Allowance claimants are aged under 50 and 56% have been on IB for more than 5 years; with the average length of claim lasting over 9 years.

Whilst specific figures are not available Manchester is estimated to have the second biggest Lesbian, Gay, Bisexual and Transgender communities outside of London.

Data from the 2001 census showed that 34,500 people were providing unpaid care in Manchester

Improving the physical and mental health and wellbeing of our residents by reducing the high and persistent levels of health inequalities is NHS Manchester's greatest challenge. The changes in our population need to be effectively planned for and measured, considering how demographic change will alter demand on services and overall public health need. There will be a need to ensure that our approaches are inclusive and can respond to the needs of our diverse



communities, for example through embedding Equality Impact Assessment in our business processes, as described later in this plan.

### 3.2.2 The case for change

Here we summarise the current position in relation to the priority areas we intend to address through implementing this plan.

#### Life Expectancy

Life expectancy among Manchester's men is the worst in England, while among women it is the fourth worst. A key outcome for us is to extend life. The Local Public Service Agreement target aims to reduce the expected gap in this indicator to 4.5 years for men and 3.2 years for women by 2010.

Current trends indicate good progress, suggesting that by 2010 the gap will be 4.2 years for men and 2.9 for women compared with the current gap of 4.3 and 3.0 respectively; therefore the target is likely to be achieved, see figure 4.

Figures released by the North West Public Health Observatory, and now available as a part of the national Health Inequalities

Intervention Tool, allow us to look at the contribution of specific causes of death to the life expectancy gap between Manchester and the national average. For men, the biggest contributor to the gap remains coronary heart disease but this is now followed by deaths from digestive disease including cirrhosis. For women, deaths from digestive disease including cirrhosis are now the single biggest contributor to the life expectancy gap, having overtaken coronary heart disease.

#### Health Inequalities

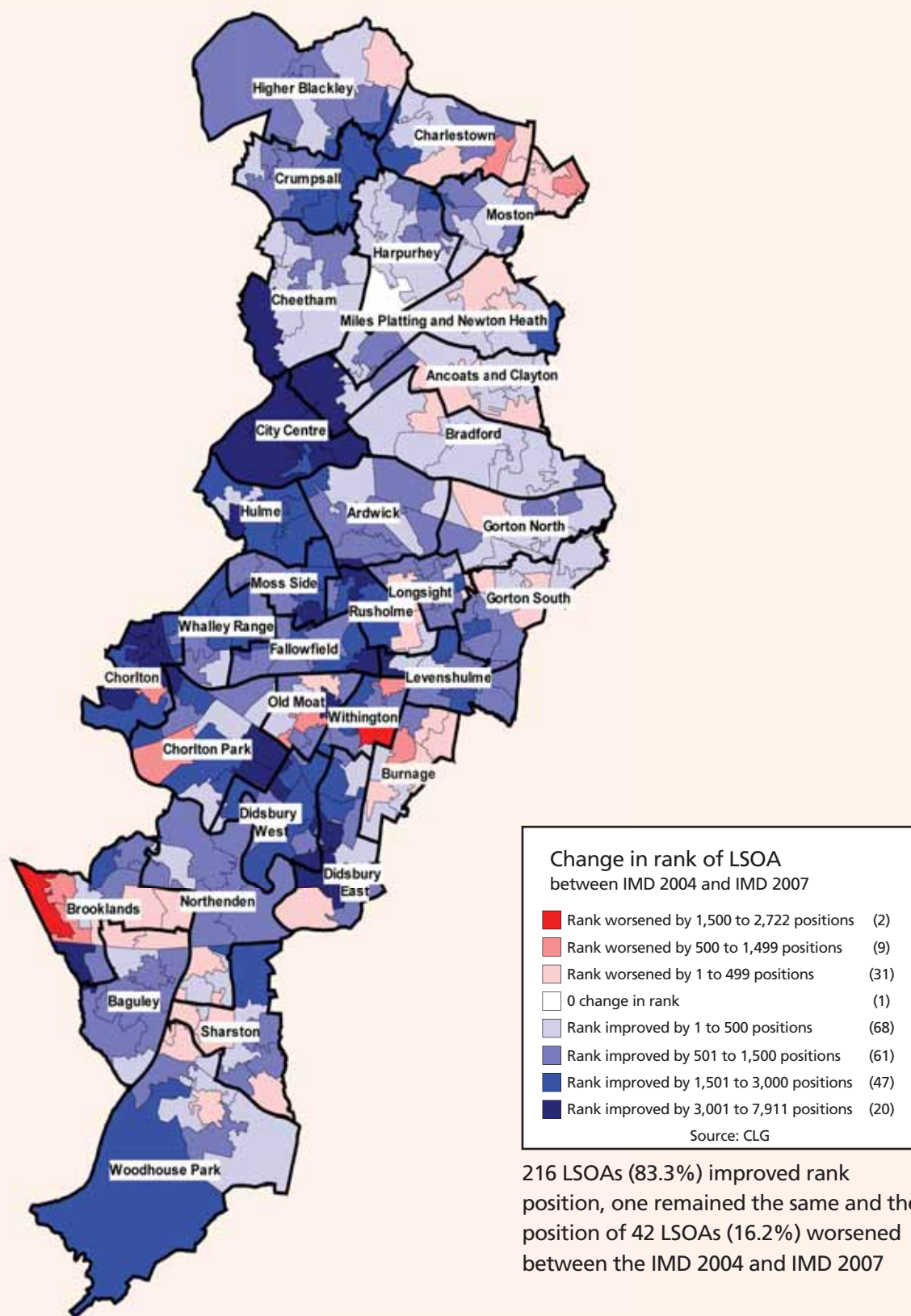
The Index of Multiple Deprivation (IMD) for 2004 found Manchester to be the third most deprived local authority in England with almost 60% of our neighbourhoods in the most deprived 10% in the country. The newly issued IMD for 2007 shows that the city's overall ranking has improved slightly from being the third most deprived local authority area to the fourth.

At sub-district level the improvement is more obvious. In 2004, 62% of Manchester's Lower Tier Super Output Areas (LSOAs) were in the most deprived 10% of LSOAs in England. In 2007, this figure fell to 52%. Overall, 83% of LSOAs improved their rank position between 2004 and

**Figure 4 - Actual and projected gap in life expectancy (in years) between Manchester and England 1995-1997 to 2009-2010**



Figure 5 - IMD 2007 - Change in LSOA rank between 2004 and 2007



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2007 (see figure 5). The areas in blue represent those parts that have improved to become comparatively less deprived between 2004 and 2007. The darker the blue, the more the area has improved.

Although the pattern of deprivation remains primarily in the North and East of the City, there have been improvements across the New East Manchester area and spreading south to Central Manchester, Moss Side and Hulme. The most deprived LSOA is in Harpurhey, which is ranked the second most deprived LSOA in England.

Inequalities in health outcomes and access to health services strongly mirror the pattern of deprivation (see figure 6). Directly standardised mortality rates (DSR) for the period 2004-2006 show a clear gradient with the most deprived 20% of LSOAs (Quintile 1) having an All Age All Cause Mortality (AAACM) rate 50% higher than the least deprived 20% (941.6 per 100,000 compared with 625.9). This gradient persists at different levels across all the major causes of death.

Premature mortality rates from circulatory diseases in the most deprived quintile are over double those in the least deprived quintile. There is a similar sized gap for accidents,

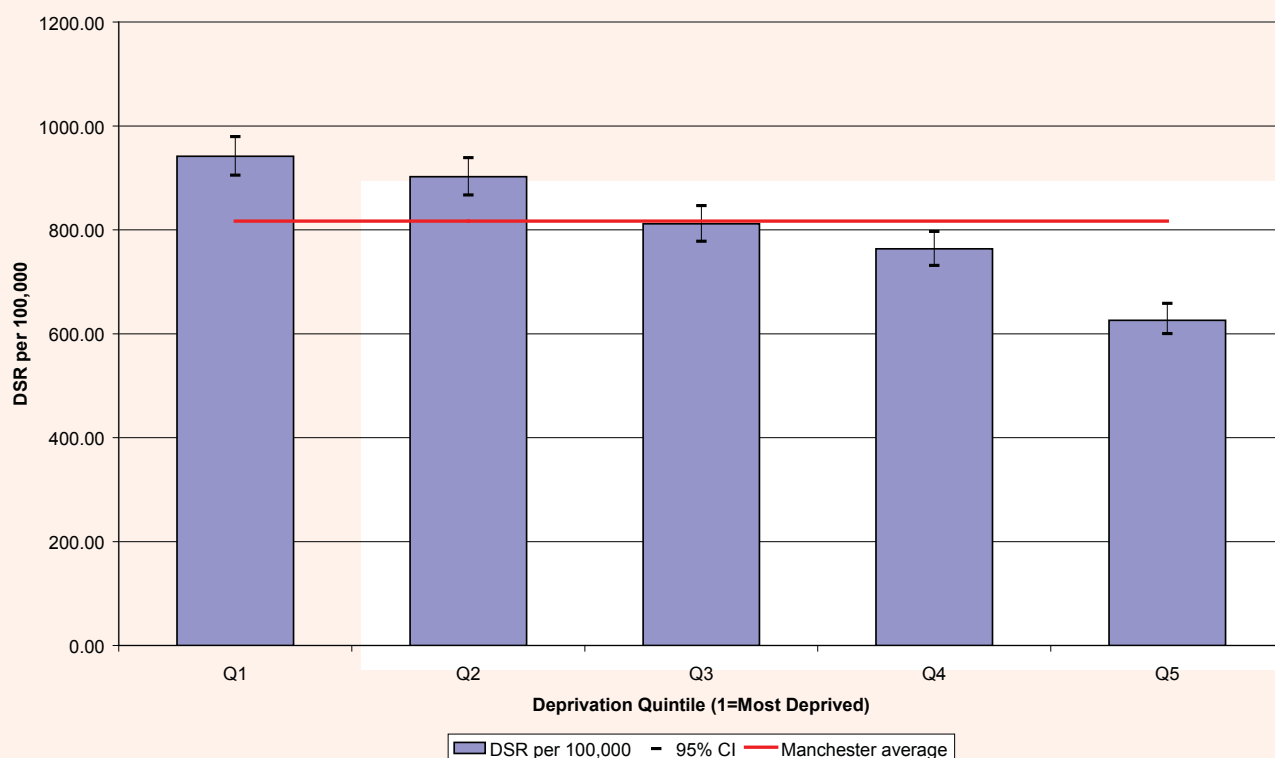
digestive diseases and respiratory diseases. The deprivation gradient for premature mortality from all cancers is slightly lower at around 40%.

The existence of inequities in access to high quality health and social care services has also been shown to have an impact on inequalities in health outcomes. A recent equity audit of stop smoking services in the city highlighted the existence of an inverse relationship between access rates and outcomes, whereby the areas that most clients came from had the lowest rates of successful quitters. In 2006/07, around 28% of clients lived in the most deprived 20% of LSOAs compared with 9.5% living in the least deprived 20% of LSOAs. However, quit rates fell with increasing deprivation and clients living in the least deprived 20% of LSOAs had a quit rate of 56.6% compared with a quit rate of 43.2% among clients living in the most deprived 20% of LSOAs.

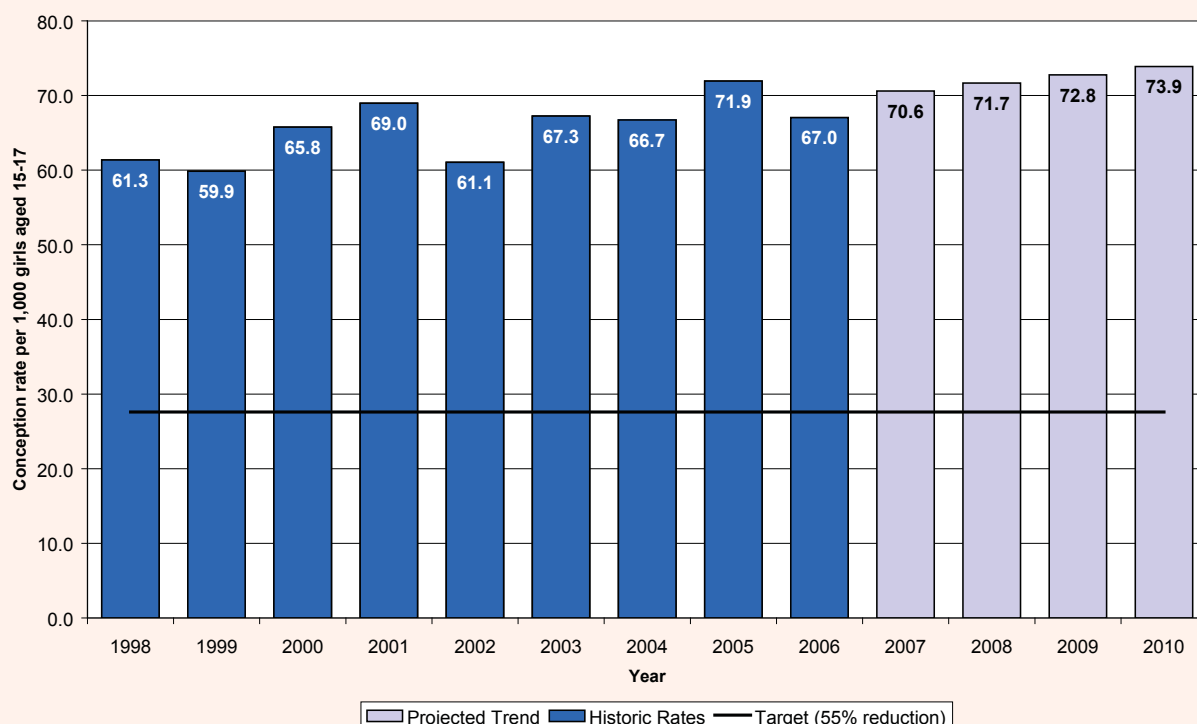
### Conceptions Among Teenagers

Reducing the high number of teenagers who become parents is central to the city's wider ambitions for reducing social exclusion, health inequalities and child poverty. Manchester is required to achieve a 55% reduction in the under-18 conception rate by 2010. Between 1998 and 2006

**Figure 6 - Directly Standardised Mortality Rate (DSR) from All Causes of Death (All Ages) Deaths to Manchester Residents Registered in 2004-2006**



**Figure 7 - Under 18 Conception rate in Manchester Actual and Projected Rates 1998-2010**



the under-18 conception rate increased by 9.3% (from 61.3 per 1,000 girls aged 15-17 to 67.0). This compares with a reduction of 13.3% in the rate for England as a whole. However, there are signs of improvement. Between 2005 and 2006, the under-18 conception rate fell by 8.6%. This is equivalent to a 9.1% reduction in the actual number of under-18 conceptions, from 591 in 2005 to 537 in 2006, as illustrated in figure 7.

### Alcohol Related Disease

It is estimated that more than 1 in 5 adults in Manchester (22.5%) consume alcohol at 'hazardous' levels and 8.8% do so at levels that are harmful to their health. Deaths from alcohol related diseases, such as cirrhosis of the liver, account for an increasing proportion of the life expectancy gap between Manchester and England and Wales as a whole. In 2006/07, there were just over 9,000 hospital admissions for alcohol related diseases – a rate of 2,222.8 per 100,000 population. If no further action is taken, it is estimated that the number of admissions for these causes will more than double to nearly 23,000 by 2013/14 (see figure 8).

### Childhood Obesity

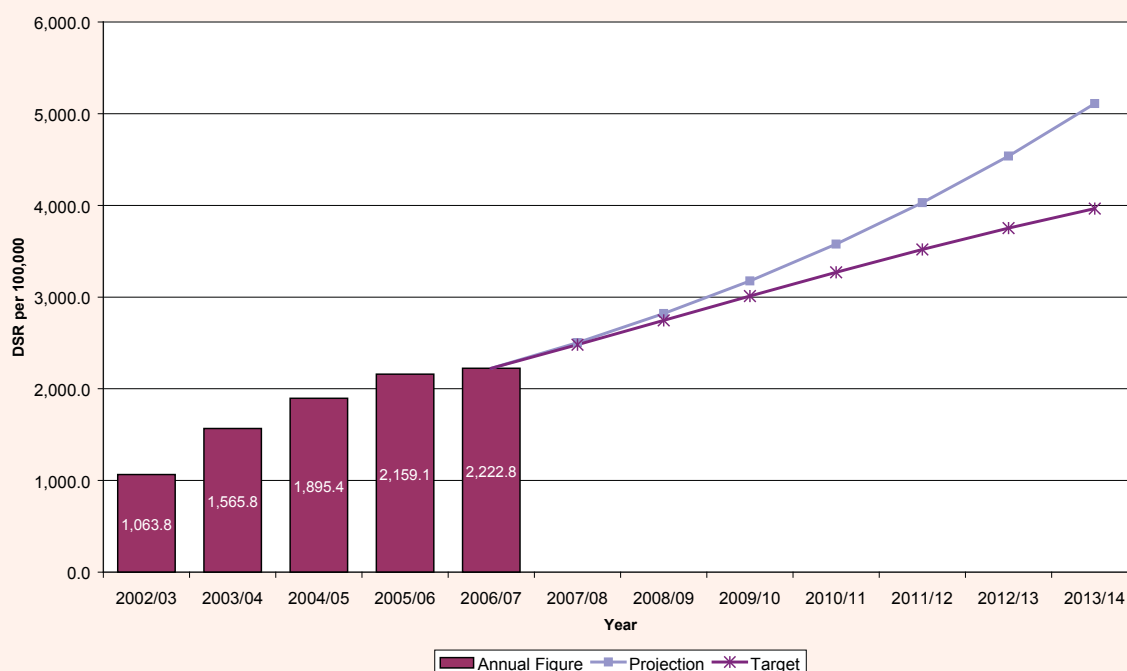
Childhood obesity is closely linked with early onset of preventable disease and it has recently been estimated that, if no action is taken, 1 in 5 children in England will be obese by 2010. The most recent figures show that, in 2006/07, 22.8% of primary school age children in Year 6 (23.9% of boys and 21.6% of girls) were obese. The prevalence of obesity among primary school age children in Manchester is above the average for the North West region as a whole; with the level of obesity among girls in Year 6 (21.6%), the highest in the North West.

### Patient Safety

It is estimated that in the developed world, 1 in 10 patients who are hospitalised will suffer unintended harm and 1 in 300 will die as a result of medical error. Although there is currently insufficient information to accurately assess the extent of avoidable harm within Manchester's NHS, our Board has explicitly committed to the principle of 'First Do No Harm'. We need to ensure that emerging evidence and knowledge about patient safety are applied to minimise risks and that we can progress to demonstrably reduce the risk of harm in the Manchester healthcare system.





**Figure 8 - Comparison of Indicative Trajectories for Alcohol Related Admissions (NI 139) 2002/03 to 2013/14**

## Quality and Availability of Primary Care Services

Around 80% of patient contacts with the NHS take place in primary care. In Manchester there are a number of areas that currently have poor or no access to certain primary care services. There is clear evidence that a strong primary care system leads to a highly cost effective health system that also drives down inequalities. Manchester is currently performing below the national average in terms of access to a GP within 48 hours, although the rate of improvement is increasing faster than the national rate. We need to increase capacity and availability of NHS services, reduce unnecessary demand for GP services by working with other local primary care professionals and streamline the patient journey through primary care.

## Long Term Conditions

Addressing the prevention and management of long term conditions is critical to promoting health gain, managing demand and supporting effective use of resources. This underlines the importance of long term conditions as contributors to the gap in life expectancy between Manchester and the rest of England.

World Health Organisation data suggests that at least 80% of premature heart disease, stroke and diabetes, as well as 40% of cancers could be prevented through basic healthy lifestyle interventions. For those who already have a long

term condition, evidence suggests that systems of proactive, managed care and supported self-care can translate into better quality of life for patients and carers, as well as more efficient use of resources. Nationally, approximately 80% of all consultations with GPs and 60% of hospital bed days are related to care for a long term condition or associated complications.

In discussing long term conditions it is important to recognise that this includes mental health, both as a long term condition in itself and as a significant co-morbidity in other long term conditions such as diabetes, heart disease, stroke and chronic obstructive pulmonary disease. For people with severe enduring mental health problems there is evidence that their physical health needs can be seen as secondary to their mental health needs, resulting in poorer disease management and health outcomes.

Providing timely, high-quality and appropriate interventions for people with psychosis has been a significant policy theme because of the impact upon recovery, well-being and relapse prevention. It was an important theme in the National Service Framework for mental health, which set out a blueprint for the development of modern mental health services across the country. At the cornerstone of service delivery was the development of crisis resolution and home treatment services, which were associated with delivering real

treatment choice for patients and other benefits, including a reduced requirement for traditional hospital-based models of care. Commissioners in Manchester have already invested in the development of crisis resolution and home treatment services, but it is clear that not all the above benefits have been realised so far.

### Access to Planned Care

Access remains the most commonly complained about aspect of healthcare in Manchester and is clearly a priority for patients. By December 2008, the Department of Health 18 week Referral to Treatment Target requires primary care trusts and service providers to deliver definitive treatment to elective patients within 18 weeks of their initial referral. Working towards this target has been a tremendous catalyst for service and workforce redesign resulting in a shorter patient journey and a shift of appropriate diagnostic and treatment activity into community settings.

Considerable progress has been made in reducing the referral to treatment times across Manchester and as at June 2008 the 18 week target was achieved in 93.1% of cases where hospital admission was not required and in 84.3% of cases where it was. However, some surgical services require significant improvement and there are access problems for other services including ophthalmology, dental services and dermatology.

### Access to Urgent Care

Urgent care is a vital element of the health economy that must be particularly responsive to patient need and demand. Managing demand for urgent care in Manchester has proved to be a major challenge, with attendances at Accident and Emergency (A&E) departments increasing by 42% between 2005/6 and 2007/8. This has contributed to difficulties in meeting key targets on waiting times, emergency admissions and excess bed days. Many attendees at A&E could be treated appropriately in other settings and a key aspect of the challenge is to understand patients' choices and ensure they increasingly access suitable alternative services where appropriate.

### 3.2.3 A system-wide priority - improving mental health services

Manchester has some of the highest levels of mental health problems in England. NHS Manchester is among the highest spending primary care trusts in the country on mental health services, but outcomes have consistently fallen short of

expected levels. The importance of achieving better mental health and wellbeing including more effective mental health services is reflected in our inclusion of mental health as a core theme running throughout this plan and described explicitly in a number of the strategic initiatives.

To reflect the importance of mental health to our future commissioning, we have also developed it as the subject of an eleventh strategic initiative, which summarises our overall aims for mental health. John Boyington CBE's recent report on mental health services in Manchester will strongly influence our operational plan and provides significant levers for the required programme of change.

## 3.3 Where are we now? Partnerships

If NHS Manchester is to achieve its goals it needs to work closely with individuals, communities and other organisations. The most recent report by the World Health Organisation on health inequalities across the world (World Health Organisation, 2008), illustrated again that many factors are influential in creating and sustaining health inequalities, particularly economic circumstances. We must therefore make a determined effort to stimulate and co-ordinate partnerships between people and organisations with common objectives to improve health.

This section explains the key partnerships we have created and the relationships that must be nurtured to make the progress we aspire to in delivering this plan. Crucially our approach will reflect a growing understanding and knowledge of patients and the public; particularly of their needs, experiences of the NHS and preferences for how the NHS will work for them in future.

### 3.3.1 Working with Manchester City Council

Manchester City Council is NHS Manchester's key partner in the goal to improve health and tackle health inequalities. Not only do we work closely together in developing and commissioning key services for the public, the city council's lead role in fields such as regeneration, economic development and planning makes it a critical player in addressing the social determinants of health.

NHS Manchester has increasingly played a strong leadership role alongside the city council in the key thematic groups of the Manchester Partnership (the local strategic partnership),



including the Adults Health and Wellbeing Board and Children's Board. We have helped to shape an approach to strategic shared commissioning - the Manchester Model - that will provide a powerful vehicle for the next stage of our work to achieve joint goals as set out in the Manchester Community Strategy (2006-2015) and Manchester Local Area Agreement (2008-2011). The Local Area Agreement not only contains priority improvement targets consistent with the priorities in this plan, it also focuses on the wider determinants of health that in the medium to long term will lead to better health outcomes for local people.

Our partnership with the city council is exemplified by the Manchester Joint Health Unit, which was established in 2002 to coordinate programmes to tackle health inequalities, and is jointly funded by both organisations. The Unit takes the lead role in implementing the public health high impact changes for local government and ensures that NHS Manchester and other NHS organisations in the city contribute fully to the delivery of the Community Strategy and Local Area Agreement. It facilitates the involvement of NHS Manchester in the work of the Manchester Partnership and provides an interface with elected members and senior officers of the Council on a wide range of health issues. The support functions provided by the Unit include policy development, health intelligence and research, and programme and resource management. It has also led the production of our Joint Strategic Needs Assessment.

Another key partnership with the city council is in the joint commissioning of mental health and social care services, which must be a specific focus for us over the next five years. Having jointly commissioned a report by John Boyington CBE during 2008 on the progress and effectiveness of arrangements for both the commissioning and provision of these services, we must work closely together to ensure its recommendations are now fully implemented.

Recognising the role of the NHS as a major employer, a partnership involving the NHS and the city council has secured local employment and development opportunities in the NHS for Manchester residents. The Joint Health Unit has worked with GPs and other healthcare providers in providing pathways back to work, while the Condition Management Programme hosted by Manchester Community Health has provided tailored support to people on Incapacity Benefit. Having been granted 'City Strategy' pathfinder status by government to tackle the high levels of worklessness in the city, there is considerable scope for building on this progress.

### 3.3.2 Practice Based Commissioning

NHS Manchester is fully committed to implementing and developing Practice Based Commissioning (PBC) as a key enabler for locally sensitive, clinically informed services which meet the needs of local populations and deliver maximum health benefits. PBC is well developed across the city and is nationally recognised as leading the way in this important area of NHS reform.

PBC is organised around three geographical commissioning hubs in North, Central and South Manchester. Its focus has been to work with the acute service providers to transform clinical pathways for urgent and planned care. Examples of other areas of clinical reform delivered by PBC reflect and mirror the needs of the local population. We must continue to work closely with the PBC hubs to explore ways that will consolidate this success and specify how the role of PBC will increasingly support the wider objectives of NHS Manchester. This will be extended in the role of PBC in the commissioning of primary and community services.

### 3.3.3 Working with Providers

NHS Manchester aims to continue to develop a rich market of providers from all sectors, able to offer choice of high quality services for people who need them. We will also increasingly look to providers to assist effectively in improving health and reducing risk. NHS Manchester anticipates working with providers on the basis of robust challenge where appropriate and necessary, but also in solid and mature partnership, focused on achieving common goals. Section 3.4 explores these issues in more detail.

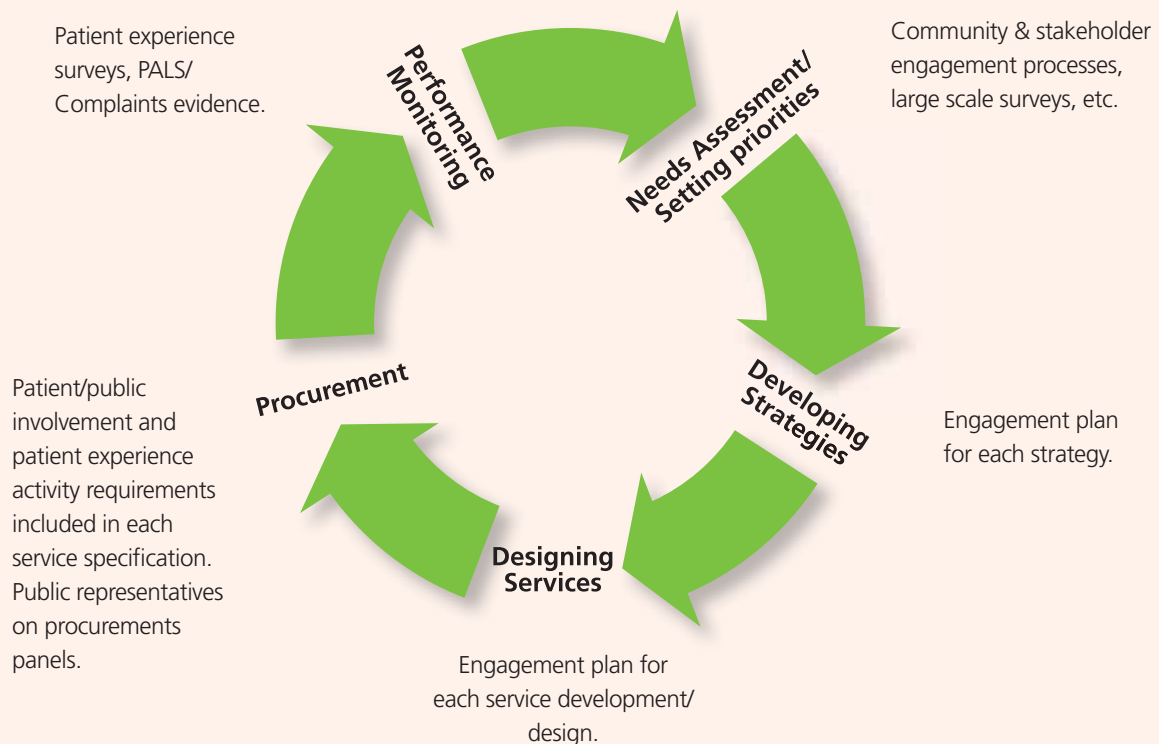
### 3.3.4 Working with Patients and the Public

NHS Manchester has a strong and innovative track record in engaging and involving patients and the general public in its work and decision making. We will continue to build on our achievements during the lifetime of this plan. In so doing, it will be contributing to reshaping the relationship between the NHS and the public, summarised in section 3.1.2 and figure 3.

The views of the local community must inform our planning, development and monitoring of local health services. Our approach to achieving this throughout the commissioning cycle is summarised by figure 9.

As mentioned earlier, we launched the Improving Health in Manchester programme to deliver an innovative planning process that would enable interested parties to influence

**Figure 9 - NHS Manchester's approach to embedding engagement throughout the commissioning cycle**



our investment plans for 2008-09. Over 150 delegates attended the launch conference in November 2007; with representation from patients, clinicians, the third sector, Manchester City Council and local NHS Trusts. A second conference was held at the end of January 2008 so that everyone could hear and comment upon the resulting priorities and proposals generated by six multi-agency working groups. As a result of this work our growth monies have been invested in a wide range of projects in 2008-09, most of which will continue to be funded recurrently.

Building on this approach we subsequently launched "Talking Health"; a programme designed to broaden our discussions by involving greatly increased numbers of patients and members of the public in our approach to commissioning services. Talking Health has a number of different components, the four initial key elements being:

- The Discovery Survey – a broad survey, delivered to approximately 210,000 households in the city, to gather information about the experiences, preferences and aspirations of our community;
- 'myNHSmanchester' – a membership scheme, already with in excess of 2,500 members and with a target of 3,000 by the end of 2008-9, which gives us the

mechanism to develop an ongoing dialogue and relationship with local people; providing information and news about local health issues as well as enabling feedback regarding their comments, suggestions and experiences;

- Focused work with 16 identified 'Communities of Interest', aligned to six diversity strands, to explore and develop bespoke engagement mechanisms that ensure full contribution to the debate; and
- Engagement around specific service developments including Urgent Care, new GP practices, Out of Hours GP services and Urgent Dental Care.

The Talking Health Discovery Survey closed at the end of September 2008. The results will provide a valuable insight into the views of our communities about current and future NHS services, helping to inform future developments including a number of the strategic initiatives described in this plan.

Interim results based on an analysis of the first 1000 responses to the survey show:

- In terms of issues which will impact on the way we plan health services in Manchester in the future, the areas



respondents felt would be the highest impact were: long term conditions; mental health problems; dental health and healthy lifestyle factors (including smoking, alcohol, diet, activity, sexual health); these were followed by infectious diseases and teenage pregnancy;

- 42% of respondents rate their experience of using health services in Manchester as either 'Excellent' or 'Very Good', with a further 28% stating 'Good'. Less than 7% give a negative view;
- GP services are particularly highly regarded, with over 42% rating them 'Excellent', although out-of-hours GP services score less well;
- People who have used Accident and Emergency recently are most likely to cite their GP being closed as a reason for attending;
- More than half of respondents chose to register at their current GP practice because it is was nearest to their home, with walking (39%) and car (31%) the most common ways of getting there;
- When asked how their GP practice could improve, the most common responses are all about improving access: 35% would like their practice to open at the weekend and 32% on weekday evenings, while 31% would like it

made easier to book an appointment. Around a quarter say no changes are needed at their practice;

- More than three quarters of respondents support suitable services being provided in community settings rather than hospitals;
- Respondents are most likely to say that investment in improving or building local health centres should focus on areas where health is poorest; and
- Respondents with long term health problems are most likely to say they would benefit from advice on how to live with their condition (37%), face to face advice and support from a health professional (36%) and better, up to date information about their condition (33%).

In addition to the Talking Health Discovery Survey, NHS Manchester gains insights into the views and experiences of patients and the public through a number of sources, for example:

- the Local Health Services Survey;
- the former Manchester Patient and Public Involvement Forum, now the LINK; and
- intelligence from our combined Complaints and Patient Advice and Liaison Service.

### **Feedback commonly received through these channels includes:**

**"We need clear patient information"**

**"We want our care provided locally and with good public transport links"**

**"We want services to be sensitive to our diverse needs"**

**"We want services to meet our individual needs"**

**"We want to be engaged with when services are being developed"**

**"We want to be able to book an appointment with our GP within 2 working days"**

**"We want our GP practices to increase their opening hours"**

**"We want improvements in customer care"**

**"We want better access to NHS dentists"**

**"We want better information and access to health improvement programmes"**



## 3.4 Where are we now? Our healthcare providers

We currently commission most of our services from:

- 9 secondary care, acute, providers;
- 3 mental health trusts;
- Our provider arm Manchester Community Health; and
- 102 GP practices (due to increase to 105 by 2009).

In addition to this we hold contracts with:

- 80 dentists;
- 115 pharmacists;
- 50 optometrists; and
- not-for-profit and independent private and voluntary sector organisations.

Through the delegation of commissioning processes for specialised services to the North West Specialised Commissioning Group, we are party to up to a further 50 service level agreements with specialised service providers.

In relation to directly commissioned services, currently two of our three main acute trusts receive proportionately low income from contracts with NHS Manchester as they also provide services to large numbers of patients from outside Manchester. This means that core commissioner status does not bring with it the same market influence as it would in, for example, a locality where an acute trust relies on its host primary care trust for 80+% of its income.

The existence of three large acute trusts and one large mental health trust within the Manchester footprint, plus five neighbouring acute trusts and two mental health trusts within easy reach for most of the population, does however offer patients a real choice and gives us considerable potential to influence the market in line with our strategy to transform health and healthcare services.

### Market Management

Our market strengths and challenges are summarised in figure 10:

**Figure 10 - Market strengths and challenges**

#### Strengths for Manchester include:

- Established providers mostly with proven track records in delivery
- The plurality and diversity of providers already available, and consequent choice available for patients;
- The market pull for new entrants from being a major city and the centre of a city region;
- The existence in certain areas of local providers, especially those from the voluntary sector, with close roots in and links to local communities;
- Local developments in procurement processes, such as the local Any Willing Provider model, and;
- Practice based commissioning innovation means that many healthcare improvements, achieved via contract management, are already occurring.

#### Challenges include:

- The existence of localised monopolies for many pathways;
- Our limited success to date in maximising the use of our market position, as core buyer, to influence reform in some sectors; and
- The lack of ability of smaller organisations, particularly from the primary care and not-for-profit sectors, to respond to market management approaches.

We have started to analyse our provider landscape in a systematic way that is focused on identifying important market development opportunities that will use competition, market making and other levers to address:

- major issues of service accessibility that are contributing to health inequalities;
- key service gaps or improved integration of existing services;
- improving patient experiences of healthcare;
- local neighbourhood health inequality issues;
- the continuing need for improved cost efficiency; and
- specific service transformation and service redesign issues.

The profile of service providers used by people from Manchester is characterised by plurality and choice,



particularly in acute secondary care. However, we know from our strategic analysis that we need to strengthen our provider landscape in the following areas:

- provision of high quality mental health services and development of service network particularly in the areas of home based treatment services;
- the quality and scale of our primary and community services infrastructure in areas of the city that experience significant health inequalities;
- the effectiveness and availability of alternative out of hospital urgent care services network;
- accessibility of joined up health improvement / prevention services with other agency services in our most deprived areas;
- enhanced ability to systematically scale up and deliver interventions around health improvement or improving resource utilisation;
- development of alternative provision;
- significant steps are already being made, for example with a Greater Manchester-wide collaboration to introduce independent sector Clinical Assessment, Treatment and Support Services (CATS) covering five high volume specialty areas (Orthopaedics, General Surgery, Urology, Gynaecology, and Ear Nose and Throat); and
- reduction in conflict of interest between commissioning and provision functions within NHS Manchester. Manchester Community Health, our provider function, is shifting to an arms-length relationship with a separation of duties between the provider and healthcare procurement and commissioning functions.

We intend to reshape our local provider profile through market making and commissioning new service contract opportunities for the third sector, in particular social enterprise organisations. We believe several of our strategic initiatives, described in the next section, will encourage local enterprises to develop their joint working approaches across social, health, economic regeneration, housing and education, and develop innovative solutions to our key commissioning challenges. We see our role developing as a World Class Commissioner to pursue market making opportunities and provide incentives for new providers and existing providers to scale up their service redesign propositions to address specific service needs of our population.

### 3.4.1 Provider quality and safety

**High Quality Care for All** strongly features the importance of the healthcare quality agenda. The report also mentions 'Never Events' as a potential option and proposes 'Quality Accounts' for providers. NHS Manchester has already undertaken much of this work locally. As mentioned earlier, our Board has already signed up to the principle of 'First Do No Harm' and we have established a list of clinical incidents that should not happen, known as 'Never Events'.

We are working very closely with our provider trusts on this agenda, and have agreed to work with them on Never Events. Similarly we will be moving forward to work alongside providers in relation to Quality Profiles, which we developed during 2007 and are similar to the Quality Accounts proposed by Lord Darzi in High Quality Care For All. The Profiles have been well received by our trust colleagues and will shortly form the basis of regular structured quality reviews with provider trusts.

In addition to the above:

- we have also embarked on being a pilot for the handover of Serious Untoward Incidents management from NHS North West to primary care trusts; and
- we are creating an internal clinical risk management system to cover our responsibilities in commissioning.

Healthcare acquired infections (HCAs) are a patient safety issue of much concern nationally and we have been working with our service providers over the last year to invest in measures that will achieve a reduction.

Within the Quality Profiles for each of our main providers we will highlight how the trusts rate against key performance indicators; including patient experience. The key areas in the quality profiles include:

- Annual Health Check;
- Inpatient Surveys;
- Mortality Figures;
- Healthcare Acquired Infections / Patient Safety Initiatives; and
- Benchmarking of Clinical Audits

In relation to mental health services, concerns about the performance of existing services and the pace of implementing improvements to patient care led us, with Manchester City Council, to commission an external report during 2008 with a remit of reviewing arrangements for

both their commissioning and provision. We recognise this as a particularly challenged aspect of current NHS services in the city and that implementing the recommendations of the subsequent report, published in July 2008, will be essential to improving the quality of care available. This will be monitored through a joint performance assessment framework.

### 3.4.2 Specialised Services

In relation to specialised services, current policy marks the approach to the specialised services market as distinct from the approach to the acute and community markets. First, the North West Specialised Commissioning Group (NWSCG) currently advises primary care trusts to be aware that demand management initiatives linked to early intervention may produce short to medium term increases in demand on specialised services. A recent statement from the NWSCG advises that “paradoxically, it is ... likely that by investing in earlier parts of the pathway the result will be more pressure on what are currently known as specialised services in the future.” (North West Secure Commissioning Team, August 2008).

Our approach to demand management is, however, not based on early intervention alone but rather on a broad health improvement approach which is expected to have an impact, phased over time, across all health services including specialised care. In 2008/09 the investment priorities of the NWSCG, accounting for 95% of its growth in income, were as follows:

- Cancer;
- Cardiac services;
- Children’s services;
- Mental health;
- Sexual health; and
- Long term conditions (especially kidney and respiratory disease, and neurological conditions).

The above priorities are closely linked to those of this plan. It is to be expected therefore that the impact of the strategic initiatives described in the next section will be seen across the whole patient pathway, including those services commissioned by the NWSCG. The main challenge will be to ensure we mitigate the risk that work on early stages of pathways will generate additional activity in relation to tertiary services. An example of potentially mitigating action would be in mental health services where some evidence,

such as John Boyington CBE’s report on current service arrangements, suggests that the key to managing demand for secure services lies in part in changing organisational and clinical behaviour of secondary care providers, for example reviewing risk thresholds and revisiting financial disincentives within current commissioning arrangements.

Secondly, the policy of specialised commissioning, based on the report by Sir David Carter (Department of Health, 2006), is to ensure that providers of services have the right, high levels of skill and expertise to undertake specialist work. In practice this means that the approach of specialised commissioning is to designate specific services as specialist and to commission only from designated centres. This is a different approach to the market management approach for acute and community services. Both approaches emphasise quality, effectiveness and patient experience, but the former has less emphasis on choice and competition and a higher emphasis on sustainability and provider security.

## 3.5 Where are we now? Resources

NHS Manchester is broadly in a sound financial position and has a track record of achieving a small surplus at year end. A surplus of £0.1m was delivered at the end 2006/07. A similar position was maintained in 2007/08 and we met our revenue control total requirement of achieving between break-even and a £2m surplus; reporting a £1.1m surplus at year end (see figure 11).

**Figure 11 - Income and Expenditure**

	2007/08 £000	2006/07 £000
Revenue Resource Limit – Total Income	846,730	781,633
Total Expenditure (excluding non discretionary expenditure)	845,583	781,457
Operational Financial Balance – surplus / (deficit)	1,147	176

### 3.5.1 The Current Financial Year (2008/09)

In 2008/09 we received an uplift in the baseline allocation of £45m (5.5%), which together with an underlying recurring surplus of around £20m, enabled us to fund many new developments identified as part of the Improving Health in Manchester programme described earlier. In 2008/9 the



estimated unavoidable pressures amounted to some £45m. A £5m contingency fund was created to cover any financial risks and growth monies were released to fund the Improving Health in Manchester initiatives.

This additional investment supports our aim to improve health, reduce inequalities and help people to live independently in their own homes for longer. The principles which are increasingly influencing NHS Manchester's financial decision making during 2008/09 include the following:

- invest more money in community services, primary care (including dentistry) and programmes that support people in staying healthy;
- respond to the potential unavoidable impact of policy in areas such as continuing care, mental health and critical care that will need to be funded;
- invest in Clinical Assessment and Treatment Support services (CATS);
- consider carefully the uplifts required to further develop specialist services;
- meet the 18 weeks referral to treatment time standards using non-recurring funding in 2008/9; and
- stabilise expenditure in hospital services, with a shift of resources from urgent to scheduled care.

We are forecasting the achievement of a planned surplus of £2m in 2008/09; as part of the requirements specified in the 2008-09 Operating Framework.

We will achieve our control totals over the next five years. In line with NHS North West guidelines we are forecasting a 20% decrease in surplus in 2009/10, to be maintained thereafter. The project allocations, expenditure and surplus for the five year period are set out in figure 12.

We will require some flexibility to carry forward a small surplus from 2010/11 to 2011/12 and this plan assumes that this is the case.

### 3.5.2 Key Assumptions for the Forecast Financial Position

We have applied the guidance issued by NHS North West in assuming a 5.5% uplift for allocations in 2009/10 and 2010/11 plus a 4% increase in 2011/12 and 2012/13. We have also considered a different range of revenue growth assumptions should the allocation be altered to a range between 5.5%, to 6.3%.

Our population forecasts predict a substantial increase in population at an average growth of circa 1.6% per annum over the period covered by this plan. Currently within the NHS there is no mechanism to enable big changes in population to be reflected within baseline allocations. Within Manchester there have also been historic concerns raised that the resident population had not been properly recorded within the last census.

Where an increase in the population moves a primary care trust further away from its target allocation, the trust may expect to receive a relatively high level of annual uplift compared to others. However, the increase in Manchester's population is likely to be larger than the differential uplift that it might expect to receive, which presents us with a challenge that other organisations without population increases do not face. Within this plan we have been required to make substantial efficiency savings to enable the additional demands of a rising population to be financed, which represents a risk that other primary care trusts may not have.

For expenditure uplifts we are also following guidance from NHS North West in assuming:

- an 8% uplift for prescribing costs;
- a tariff inflation baseline minus 3% (i.e. 2.8% net for 2009/10); and
- a non tariff expenditure as per tariff inflation.

Overall, although our underlying financial position is currently sound, significant investment in improving health will require

**Figure 12 - Projected Allocations, Expenditure and Surplus**

	2008/09			2009/10			2010/11			2011/12			2012/13		
	Rec	Non	Total	Rec	Non	Total	Rec	Non	Total	Rec	Non	Total	Rec	Non	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
<b>Allocations</b>	856.0	49.1	905.1	921.6	23.3	944.9	972.3	24.2	996.5	1013.2	20.7	1034.0	1051.8	20.7	1072.5
<b>Expenditure</b>	848.0	55.1	903.1	920.0	23.3	943.3	970.7	24.2	994.9	1011.6	20.7	1032.4	1050.4	20.5	1071.0
<b>Surplus</b>	8.0	-6.0	2.0	1.6	0.0	1.6	1.6	0.0	1.6	1.6	0.0	1.6	1.4	0.2	1.6

the release of resources from existing commitments on a pound-for-pound basis. This means that investment will need to be directly matched by cash releasing efficiency gains or decommissioning. The section on affordability later in this plan illustrates how we will achieve this.

### 3.5.3 Small Area Resource Allocation

We have used a number of techniques to give effect to small area resource allocation policy. Our approach allocates secondary care and prescribing budgets to practices and attributes costs to them each month in order to monitor spending at that level. It also calculates the distance from target of each practice, comparing actual to target spending. This has enabled us to develop and implement a 'pace of change' financial allocation policy in 2008/9, ensuring that the groups of practices furthest below their target allocations have received a disproportionately higher level of growth funding, thereby moving to a more equitable distribution of resources at practice based commissioning hub level.

We have also developed a multi-factorial assessment of need at ward level in Manchester to enable rational decisions to be taken on the priorities for new investment in primary care as part of the Strategic Service Development Plan (SSDP). This approach to equitable decision-making within NHS Manchester has underpinned early procurement decisions on the equity in primary care national initiative for three new GP practices and a GP-led health centre, and the procurement of dental services. This assessment has taken account of relative needs, existing patterns of provision and the results of engagement with local communities. We are currently in the vanguard of procuring the new GP practices and GP-led health centre to become operational early in 2009.

Using the expertise within the Joint Health Unit and the geographic information database developed by Manchester City Council, we are well placed to exploit our understanding of health and other needs at ward and super-output area. We will use our community development services/healthy living network to match health resources to need for the most deprived sections of the local community.

### 3.5.4 Activity and Contracting

#### Secondary Care

The current pattern of expenditure on healthcare services within Manchester is broadly a traditional one. Highest levels of investment are in secondary care services, followed by primary and community services, with the least investment in specific health improvement programmes. We hold 9

non-specialist contracts with acute trusts. In 2007/08 the budgeted spend for these contracts totalled £292m. The budgeted spend for 2008/09 is illustrated in appendix 1, split by outpatient spells, emergency and elective.

A further £32m of expenditure is budgeted for other areas of secondary care, including prison services, non-contracted activity and continuing health care.

A useful data source designed to support the development of world class commissioning priorities is the NHS Institute for Innovation Better Care, Better Value tool. Using a range of national databases, the tool offers the opportunity to benchmark and analyse financial and clinical data to identify opportunities to improve efficiency and effectiveness. For example, the tool indicates that in Quarter 3 2007/8, we had more emergency admissions than the national average. This was an improvement on our previous quarter but still indicated a potential productivity opportunity of just over £3.5m. In addition to this, in quarter 2 2007/8 we had the second highest relative level of outpatient appointments in the North West, representing a potential productivity opportunity of over £10m. Analysis of this kind illustrates the opportunities to implement the pound-for-pound investment principle described later in this plan.

#### Mental Health

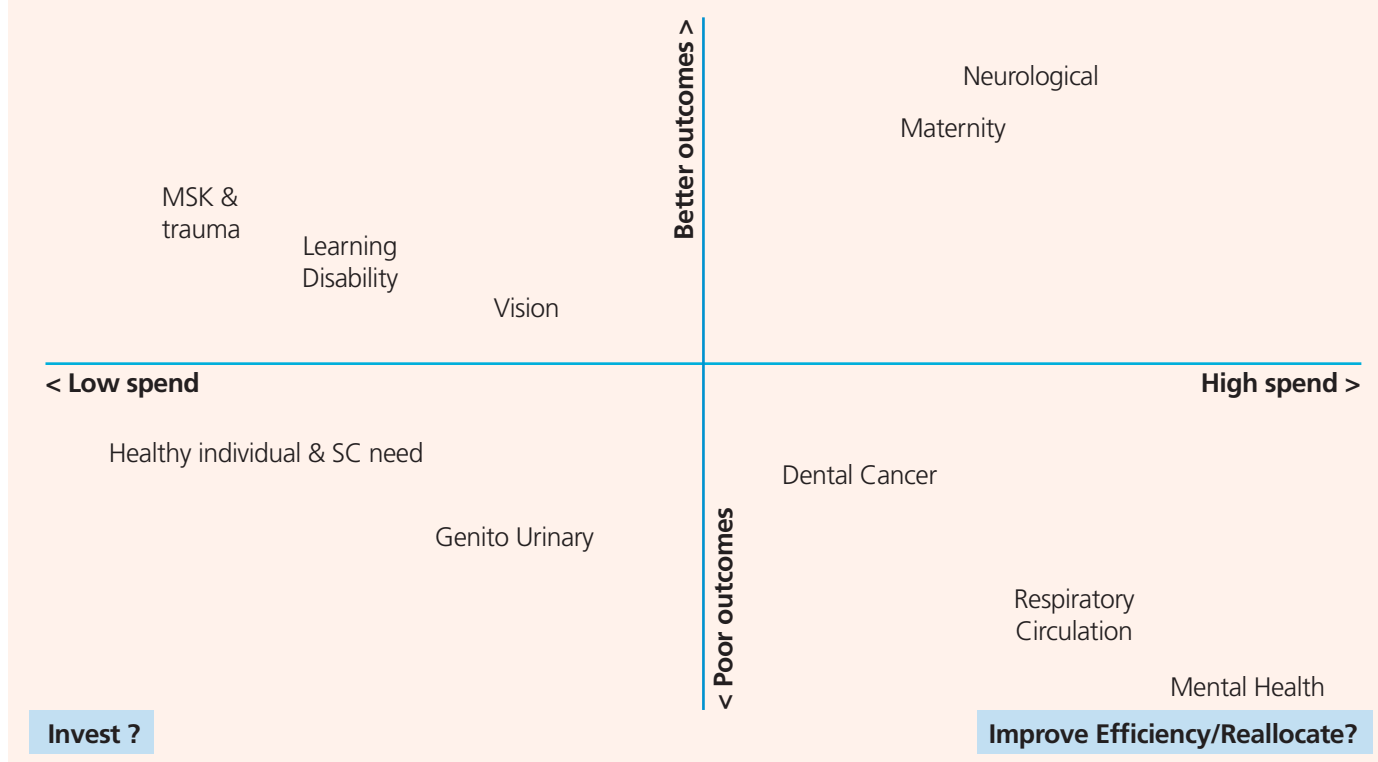
NHS Manchester commissions mental health services for a registered population of approximately 450,000. An initial analysis of information on NHS spend for 2006/2007 indicates that Manchester spent significantly more than most other primary care trusts in the North West on mental health overall, approximately £86m and on a per head basis £190. The figures for 2008/2009 indicate that due to significant new investment this figure has increased by 17%, totalling an approximate £110m spend on mental health services for Manchester.

Spending per head is well above average on child and adolescent mental health services (CAMHS), adult services, secondary care services, specialised commissioning including secure services, prevention and health promotion, user engagement, the voluntary sector and the private sector both separately and when combined.

However NHS Manchester records one of the lowest spends on primary care mental health, with this being less than 1% of the total spend, and on older people's services with 15% of the spend. The main spend is on adults with 78%, although older people's services continue to be well thought of across the health economy.





**Figure 13 - Programme budgeting data: spend vs. outcomes**

A significant resource is allocated to secure and specialised commissioning. In 2006/2007 this was estimated at just over £23m, including NHS contracts and out of area placements, mainly in medium and low secure settings in the independent sector. This equates to approximately 120 Manchester individuals in secure hospitals as of 31st March 2008. This is the highest number in the North West.

The investment in the commissioning process in Manchester is high in comparison to other primary care trusts in the North West with clear joint commissioning arrangements for the commissioning of mental health services. A key priority for commissioners is the development and management of all mental health contracts. The joint commissioning arrangements have been strengthened to ensure there is a robust framework for commissioners enabling the performance of contracts to be actively managed. There are currently 41 block contracts, 7 statutory and 34 non statutory, and approximately 50 spot purchase contracts for individual placements, with 95% being for adults of working age.

### Primary Care

In primary care we hold contracts with General Medical Practice (102 contracts, £63m budget) and Dentistry (80

contracts, £23m budget). Budgets also exist to contract for out of hours services (£4m) and prescribing costs (£87m). Similar contracts are in the process of development for pharmacy services and optometry. Currently these services are provided by 115 pharmacies and 50 optometry practices, although the bulk of the expenditure does not appear in our discretionary budget.

### 3.5.5 Programme Budgeting Data

Programme budgeting data allows primary care trusts to compare their expenditure and performance with others across the country on a range of healthcare categories or programmes. Analysis of the latest programme budgeting data available (2006/07) is shown at appendix 2.

We have higher than average spend in a number of areas, with respiratory system problems and mental health being significant outliers where we are spending considerably more than other primary care trusts. We have used the programme budgeting data to compare our expenditure with the health outcomes achieved in each programme. This is shown in figure 13:

The outcomes we measured were:-

#### **Mortality:**

- Genito-Urinary Medicine
- Cancer
- Mental Health
- Circulatory problems
- Respiratory problems
- Healthy Individuals

#### **Admissions:**

- Neurology
- Musculoskeletal
- Infectious Diseases
- Learning Disabilities

#### **Trauma & Orthopaedics**

- Accidents

#### **Maternity**

- Live births

With regard to registered populations at the end of March, these were:-

**2006/07** 524,031

**2007/08** 529,141

Despite learning disability and musculoskeletal disorders being areas of low spend, demonstrated outcomes are relatively high. However, we do have other categories where there is relatively high spend and poorer outcomes; mental health, respiratory and circulatory disorders in particular. We have a significant cost variance, as highlighted in appendix 2.

While programme budgeting information such as this requires further testing and validation it does provide some important evidence to help direct NHS Manchester's strategy in regard to improving health, improving healthcare services and in generating efficiencies. Further consideration of this is given later in the section on affordability.

### **3.5.6 Resources Conclusion**

NHS Manchester is in a financially secure position and has achieved planned surpluses since its inception in 2006. It does not however have large amounts of uncommitted growth to underpin this plan. Delivery of the plan therefore will be based on pound for pound achievements of efficiency and decommissioning.

The pound for pound principle is not only an appropriate financial planning tool; it is also an enabling factor in achieving our strategic goals of focusing on health

improvement and ensuring healthcare services are fit for the 21<sup>st</sup> century. Our current provider portfolio already has many strengths but very significant change is required in order to:

- ensure that providers are able to deliver the personalised, quality care that patients expect to choose;
- ensure that planned care is the usual means to receive healthcare, not emergency care;
- obtain efficiencies and improved outcomes where outcomes are currently poor; and
- ensure that there are appropriate providers able to join NHS Manchester in its programme to improve health.

## **3.6 Where are we now? Overall Performance**

The two following tables provide a summary of the performance of NHS Manchester to date against key national and local targets and policy requirements. The overall picture is a mixed one and illustrates the scale of the challenge NHS Manchester faces, but also provides good grounds for anticipating that the organisation will respond positively to the high expectations generated by this plan and will ultimately achieve its strategic goals.

The first table illustrates areas where we did well as evidenced by the Healthcare Commission's 2007/08 annual health check:

<b>2007/08 Annual Health Check Target</b>	<b>Target</b>	<b>Actual</b>
% of all patients admitted seen within 18 weeks	85% national	91.43%
% of all non-admitted patients seen within 18 weeks	90% national	95.06%
Number of 4-week smoking quitters	4,070	4,080
Mortality rate per 100,000 (directly age standardised) population from heart disease and stroke and related diseases in people aged under 75	140.7	130.3



2007/08 Annual Health Check Target	Target	Actual
The mortality rate per 100,000 (directly age standardised) population from cancer in people aged under 75 – within 06/07 tolerance	160.3	162.7
% of cancer patients with maximum wait of 31 days diagnosis to treatment	98%	99.9%
% of cancer patients with maximum wait of 62 days referral to treatment	95%	97.0%

However in some areas we did not achieve our 2007/08 target and risks remain for 2008/09.

2007/08 Annual Health Check Target	Target	Actual
Conception rate per 1000 females ages 15-17	38.9	67
% of patients spending four hours or less in all types of A&E department	98%	97.3%
48 hour GP access –National Patient Access Survey (NPAS)	87% National average	82%
Number of separate episodes of home treatment provided by crisis resolution teams as a % of target	1,540	1,003
% of referrals received by providers for first consultant outpatient appointments that are made through choose and book	90%	36.4%
Percentage of people aged 16 and over on a GP register whose smoking status has been recorded in the last 15 months	95%	82.8%

## 3.7 Our Organisational Capacity and Capability

Our current organisational capability and capacity and our development plans are the subject of our separate Organisational Development (OD) Plan which is a key enabler to this commissioning strategic plan. The OD Plan and its

underpinning work highlight the following three themes to address.

### 1. Strategy and Culture

- Having developed our vision, we need to articulate and communicate it clearly to ensure staff, partner organisations and the public understand the direction of travel and that both commissioners and providers can move forward in the same direction;
- We are at the early stages of turning our vision into reality. We have previously been in a position where effort and investment have been divided between too many initiatives which spread financial investment and energy too widely, and dilute the focus of the organisation and messages about what it has set out to achieve; and
- The process of bringing three organisations into one was a challenging one that impacted on staff morale. The document review showed variable staff morale at the time of the 2007 staff survey, just after the restructuring process was completed. The review also noted a need for more staff engagement and a greater emphasis on a rigorous performance management culture.

### 2. Structures and Processes

External assessors on World Class Commissioning in the North West commissioning assurance test pilot in 2007-08 commented that whilst the executive management team had grasped the importance of OD and were clear about the steps to be taken, the focus on team and people was too narrow. We were given an 'amber' traffic light and the recommendation that we broaden the scope to encompass infrastructure and business process needs.

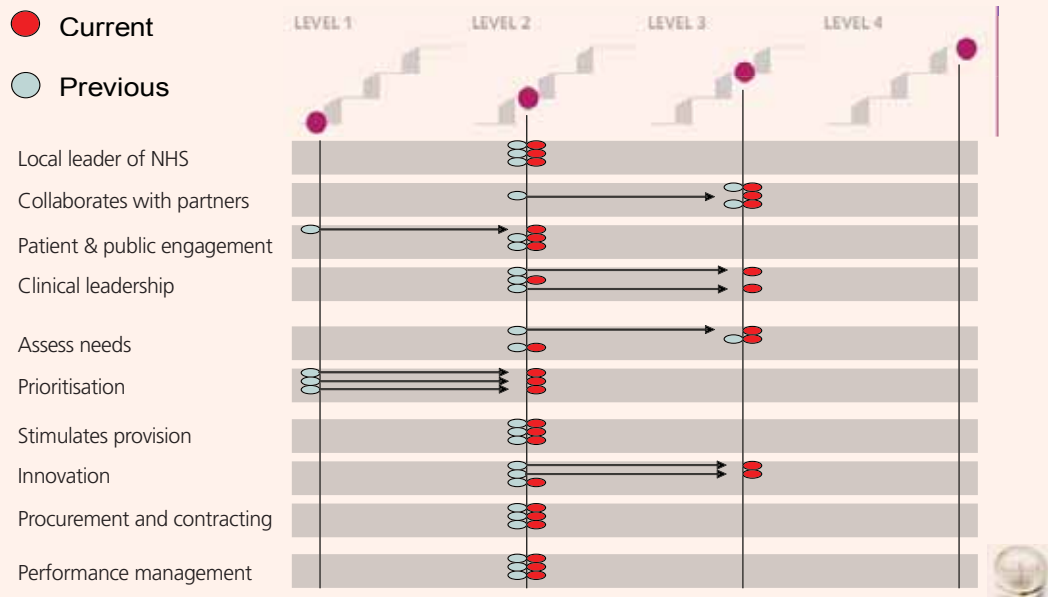
### 3. Build Skills and Capabilities

Overall the outcome of the commissioning assurance test pilot, reported in January 2008, rated NHS Manchester as having achieved baseline competency on nearly all measures, with two sub-competencies judged to be below baseline. Based on our continuous learning, we have since built on or invested in further capability and capacity as described in the OD plan (for example, in procurement, engagement and health intelligence). Figure 14 summarises the outcome of the pilot panel ratings and our current self assessment.

Our priorities for further development and examples of actions planned or in train are described in Section 5 on Delivery.

**Figure 14 - NHS Manchester competency scores - January 2008 and September 2008 self assessment (as at 19/09/2008 subject to Board final assessment)**

## Competency Self Assessment



### 3.7.1 Commissioning Intelligence and Information Technology

The national public health information and intelligence strategy for England (Informing Healthier Choices: Information and Intelligence for Healthy Populations) has highlighted the need for primary care trusts to improve the availability of basic data and knowledge to support commissioning by strengthening health intelligence resources (including innovative information systems) and developing the skilled information workforce. We have recognised the current gaps in health intelligence capacity and have agreed substantial investment in this area of work with the aim of developing a world class health intelligence function over the next two years.

A major dependency for the delivery of Lord Darzi's vision is the availability of patient information. Information increases clinical benefit, both in providing care and in supporting audit and the development of outcome and effectiveness measures. We need an informatics infrastructure that allows us to transfer patient-related information efficiently and securely, and helps us to assess our performance so that we can continue to improve and ensure the delivery of a high quality service.

Organisations across Greater Manchester share the vision to provide a comprehensive and consistent electronic record for

each individual patient, ensuring that clinicians involved with the care and treatment of a patient can access and update that record whenever and wherever they practice. As a by-product of the provision of electronic records, information will be produced which enables organisations to assess performance and improve the quality of services. The aim is that all NHS organisations across Greater Manchester realise this vision, by 2014, by deploying systems and services:

- across all settings;
- within all locations used by the NHS across Greater Manchester;
- which enable appropriate data sharing between clinicians in all those settings, across and beyond Greater Manchester; and
- that facilitate appropriate access by patients to their records.

NHS Manchester also acknowledges that equality data is equally important to the delivery of fair, personalised, effective and safe care. We have prioritised the collection of good quality equality data across all services within our single equality scheme. We have also recognised the need to work with our partners, including patients and the voluntary sector, to assist NHS Manchester in making significant progress in this area during 2008/09.



# 4 Strategy

## 4.1 Developing our Commissioning Strategic Plan

The milestones in the development of this plan can be dated back to September 2007 when the NHS Manchester Board initiated the Improving Health in Manchester programme. The origins of the programme were rooted in a firm belief that the health inequalities experienced by people in Manchester are unacceptable and that the NHS must respond by doing more to prevent ill health and promote health and wellbeing.

Moreover, our strong partnerships including a shared perspective with Manchester City Council and the increasingly valuable role of practice based commissioning, together with emerging and existing national policy and direction, supported the view that healthcare should refocus 'upstream' to minimise the blight of poor health on our communities and achieve the progress we strive for as the city's lead organisation for improving health.

The purpose of the programme was to enable stakeholders to have a genuine opportunity to shape the priorities and target new investment through our Local Delivery Plan. The Board agreed that circa growth monies should be targeted at high impact changes where investment would achieve the greatest benefit for public health.

As stated in the proposal supported at our September 2007 Board meeting: "There is no doubt that provided the planning process is effectively managed and led, the overall outcome for Manchester's population will be superior to one where (stakeholders') involvement is minimal. Confidence in Manchester Primary Care Trust as a public body that is able to give effect to the collective voice of patients and other stakeholders would be considerably increased should the programme be successfully delivered."

The ethos underpinning this approach has been central to the development of this plan and so too have the outcomes of the Improving Health in Manchester programme. The detailed discussions to agree priorities and the development of specifics proposals within each priority area have contributed strongly to our direction of travel.

### 4.1.1 Strategy Development and Line of Sight

Following the publication of the World Class Commissioning handbook and guidance in June 2008 we adopted a 'Line of Sight' to guide progress and ensure the development of this plan was the reflection of a logical and robust development process.

In reconciling our work prior to the handbook's publication against the Line of Sight we identified the **Needs and Context** incorporating:

- Improving Health in Manchester programme's identified priorities and evidence-based initiatives;
- initial debate by the Board in December 2007 to select priorities from the Department of Health's 'Vital Signs';
- feedback from the World Class Commissioning assurance test pilot;
- Local Area Agreement, approved by the Board in May 2008;
- Joint Strategic Needs Assessment, brought to the Board in June 2008;
- national policy objectives, particularly those contained in High Quality Care For All and Healthier Horizons for the North West; and
- feedback from patients and the public through Talking Health and other engagement processes.

Following development work supported by external consultancy our initial draft **Vision** and **Objectives** were produced in Spring 2008. This process was carried out in close conjunction with our Senior Leadership Team to maximise the benefit of the knowledge held across the organisation and support the sustainability and implementation of the final plan.

The **Outcomes** identified as the ten priorities in this plan were generated next and were subject to extensive debate prior to their inclusion here. We recognised early in this process that identifying ten priorities was an important but challenging task as, in keeping with the view of the World Class Commissioning assurance test panel, Manchester's poor life expectancy and health inequalities are so marked

that investment in almost any aspect of the city's health could be justified. Equally in accordance with that panel's findings, we believe that the process is however essential for us to prioritise and progress on key areas.

**Goals** for each outcome measure were then developed following consideration of the options, trends and balance between ambition and realism.

The **strategic Initiatives** then emerged as described below, under close scrutiny by the Board, Executive Directors and Senior Leadership Team. In particular we sought to ensure they were of sufficient scale to move the dials to achieve our goals.

**Delivery** plans are being initiated and will be supported through the development of regular monthly monitoring by the Board and performance management through a robust assurance framework. The strategic initiatives will be the core element of our operational plan for 2009-10.

Our first task was to reconcile our work to date to the linear 'Line of Sight' (see below).

The final plan is the result of co-development in both formal and informal sessions with the Board, Professional Executive Committee, and the Chairs of Manchester's three practice

based commissioning hubs. The outcome measures have been tested with internal and external stakeholders including the LINK, Adults Health and Wellbeing Board, Public Service Board, staff and staff side representatives. Our priorities have also been presented and discussed with the city council's Overview and Scrutiny Committee for Health and Wellbeing. A full summary of our engagement events is included at appendix 2.

#### 4.1.2 Equality and Diversity and Equalities Impact Assessment

Three of the six main equality laws place a special duty on us to conduct Impact Assessments from a race, disability and gender perspective. As we continue with our objective to have a fully functional Single Equality Scheme, we have developed an Equity Impact Assessment process that embraces:

- Race;
- Disability;
- Gender;
- Age;
- Religion or belief;
- Sexual orientation and;
- A local inequality – deprivation.

Figure 15

### WCC Line of Sight



- The JNSA went to the board in June 2008
- Vision and Objectives agreed
- Priority outcomes extensively engaged on and debated. This was particularly challenging for Manchester given the volume of health issues we need and would like to address
- Goals for each outcome measure have been established following executive consideration of the options, trends and balance between ambition and realism.
- The development of strategic initiatives was led by a designated executive director with Senior Leadership Team, Executive and board challenge on the adequacy and scale (sufficient dose) of the initiative to move the dials to achieve our goals.
- Executive leads and their teams started the work on the delivery plans which will be supported through the development of regular monthly monitoring to the board and will be performance managed through a robust assurance framework.





Equality Impact Assessments are required to be completed for all service changes and new service developments. These are embedded in our processes to ensure that we promote fairness and equity for all patients and users.

The development and implementation of this plan will also be the subject of detailed scrutiny for its impact on diverse communities across Manchester. In keeping with our mainstream business processes it too is the subject of an Equality Impact Assessment. This will identify any variation in its impact upon different communities and where appropriate describe how any such variation will be monitored and, if appropriate, mitigated. The assessment process is being overseen by our equality and diversity reference group, which includes representatives of:

- Black and minority ethnic communities
- Disability organisations including learning disability, and mental health
- Faith groups
- Older people
- Lesbian, gay and bisexual communities

The Equality Impact Assessment process will continue throughout the duration of this plan, with input from the reference group in taking forward each of the strategic initiatives.

Also in support of equality and diversity we are a member of the national Race for Health programme, which is committed to achieving real and measurable improvement in the health status, health outcomes and employment in the NHS among people from black and minority ethnic communities. The Health Intelligence Team in the Joint Health Unit will provide assistance in developing detailed plans for activity and improvement against a number of health conditions, including diabetes, perinatal mortality, heart disease and stroke, and mental health.

### 4.1.3 Testing our priorities with Manchester people

As already described in Section 3, the Talking Health discovery survey has provided useful feedback on the views of local people, supporting the choice of the ten priorities in this plan while also raising mental health as an issue that people see as having a high impact on the planning of NHS services.

In addition we specifically tested our priorities with local people by asking members of myNHSmanchester, our membership scheme, to comment on them and make any suggestions that would help us to deliver this work. At the time of writing 64 people had responded with a number of ideas which will inform the development and implementation of the strategic initiatives described in 4.3.

We have always recognised the importance of addressing mental health issues in Manchester and saw it as an integral issue to be addressed in all of the strategic initiatives. However, the lack of a specific, identifiable priority around mental health in the first draft of this plan was highlighted as a concern by a number of stakeholders including members of the public, through the Talking Health survey and the myNHSmanchester survey. The same concern was raised by members of our equality and diversity reference group as part of the initial work on our Equality Impact Assessment of this plan. Following this feedback, we have amended the plan to give greater prominence to mental health by adding a specific eleventh strategic initiative, although it also continues to be an important theme within a number of the other initiatives.

## 4.2 Goals and metrics

As shown in figure 16, ten core outcomes and goals have been identified to measure the implementation of this plan. These priorities are linked to the first three of our strategic objectives, namely to:

- reduce inequalities and to improve aspiration and wellbeing;
- commission safe and effective services; and
- develop accessible and personalised services.

They have wider links to local, regional and national developments as demonstrated in figure 17.

Our approach to addressing the fourth strategic objective, namely to develop our people and systems to enable World Class Commissioning, is described separately in the Organisational Development Plan.

Each of the outcomes has an identified metric agreed in line with national, regional and local requirements; against which we will monitor and report our progress. The baseline and links to Local Area Agreement milestones for each are set out on page 34.

Figure 16 - Improving health in Manchester

VISION

Improving Health in Manchester

OBJECTIVES

Inequalities,  
aspiration and  
wellbeing

Safe and  
effective  
services

Accessible  
personalised  
services

Developing  
our people  
and systems

PRIORITIES

1. Life expectancy
2. Health inequalities
3. Under-18 conceptions
4. Alcohol related admissions
5. Childhood obesity

6. Reducing avoidable harm from healthcare
7. High quality primary care

8. Personal Care Plans
9. Reducing waits, access to planned care
10. Access to urgent care

*Covered by  
development of  
OD Plan*

*I will be living a healthier lifestyle (4)*

*My family will have a better opportunity to live a longer healthier life (5)*

*I will be receiving higher quality clinical care (3)*

*I will be receiving more integrated seamless care, when I need to get help from more than one organisation (7)*

*I will be receiving the best technologies as part of my care (9)*

*I will be more involved in decisions made by the NHS (1)*

*I will be receiving better customer care and an improved patient experience (2)*

*I will be receiving more personalised care (6)*

*I will be able to receive more of my care closer to my home (8)*

*My NHS will be maintaining a healthy financial position (10)*

'Healthier Horizons for the North West' Touchstone Tests

Local Area Agreement

Vital Signs

World Class Commissioning Data Packs



Figure 17 - NHS Manchester Goals and Links to Local Area Agreement

	Outcome	Goal	Metric	Baseline	LAA Milestone (2010)	5-year milestone (2013)	Long-term target (2015)
Inequalities, aspiration and wellbeing	1. Life expectancy	To increase the average life expectancy of Manchester residents to 80 yrs	Average life expectancy at birth (in years) for men and women combined	75.8	77.0	78.7	79.8
	2. Health Inequalities	To ensure that the city is no longer among the top 5 most deprived local authorities in Eng	Rank of Index of Multiple Deprivation 2007 (IMD 2007) - Average score *	4	-	-	6
	3. Under-18 conceptions	To reduce the under-18 conception rate by 55% from the 1998 baseline	Rate of conceptions to girls aged under-18 per 1,000 girls aged 15-17	67.0	27.6	27.6	27.6
	4. Alcohol related admissions	To halt the expected rate of growth in alcohol-related admissions	Directly standardised rate of alcohol-related admissions per 100,000 pop	2222.8	3270.0 -307 less (1%)	3964.7 -1,146 less reduction	4296.4 -2,187 less per year)
	5. Childhood obesity	To reduce and sustain a reduction in levels of childhood obesity	% of school children in Year 6 who are obese	22.78%	22.98%	#22.98%	#22.98%
Safe and effective services	6. Avoidable Harm	To reduce and sustain the number of C Difficile infections by 45% in line with national targets	Number of C. Difficile infections	620	343	#343	#343
	7. High quality primary care	To increase the percentage of practices offering extended opening, in compliance with Department of Health guidelines	% of GP practices in the PCT offering extended opening, in compliance with DH guidelines	44.0%	55.0%	70.0%	80.0%

	Outcome	Goal	Metric	Baseline	LAA Milestone (2010)	5-year milestone (2013)	Long-term target (2015)
Accessible, personalised services	8. Personal Care Plans	To ensure that all people with long-term-conditions (LTCs) are supported to be independent and in control of their condition maintained by personalised care plans.	% of patients with diabetes in whom the last HbA1c is 7.5 or less **	68.5%	73.0%	82.0%	88.0%
	9. Access to planned care	To ensure that 90% of admitted and 95% of non-admitted patients are seen within 18 weeks (at each provider in each month)	% of admitted and non-admitted patients seen within 18 weeks	60.8% (admitted); 79.4% (non-admitted)	90.0% (admitted); 95.0% (non-admitted)	90.0% (admitted); 95.0% (non-admitted)	90.0% (admitted); 95.0% (non-admitted)
	10. Access to Urgent Care	To ensure that at least 98% of patients spend less than 4 hours in A&E (at each provider in each month)	% of patients spending four hours or less in all types of A&E department	97.3% (YTD 30/3/2008)	98.0%	98.0%	98.0%

\* Timing of target is dependent on date of next version of IMD score

\*\* This is a proxy measure to examine adherence to a care plan and will be superseded by the new Vital Sign measure ("Proportion of people with long-term-conditions (LTCs) supported to be independent and in control of their condition") when a metric is available

# Targets to be revisited after 2010

## 4.3 Strategic Initiatives: to deliver goals

Our strategic initiatives define how we intend to achieve the goals set out above. In each case, a strategic initiative encompasses a number of work programmes that will deliver the changes required to make rapid progress. The role of the different programmes ranges from community engagement that promotes and enables better health to service redesign and procurement.

### 4.3.1 How the initiatives were selected

Our strategic initiatives were selected using the prioritisation criteria set out in figure 18.

Using guidance from NHS North West, a Multi Criteria Analysis (MCA) tool was developed, incorporating criteria and weighting used in the prioritisation of proposals emanating from the Improving Health in Manchester programme.



**Figure 18 - Prioritisation Criteria**

IHiM Criteria	Weighting	Rationale
Reducing health inequalities i.e. narrowing the gap between those with the poorest health and those with the best health	25	We will prioritise initiatives which are based on evidence that they are likely to improve the health of those with the poorest health in Manchester. Poor health will normally be described in relation to specific disease areas but may be evidenced by aggregated indices such as multiple deprivation.
Health gain i.e. improving health among Manchester people, without necessarily reducing inequalities between different parts of the city	24	We will prioritise initiatives which improve the health of the whole population of Manchester. Where there is a conflict between this criterion and criterion above, criterion above will take precedence.
Improving access to services	20	We will prioritise initiatives which improve access insofar as they <ul style="list-style-type: none"> <li>a) reduce travelling time, cost or inconvenience for primary and community services including services which can be transferred from hospital settings, and/or</li> <li>b) reduce waiting times for health services, and/or</li> <li>c) increase the overall number of people able to obtain a health service in a reasonable timeframe and/or</li> <li>d) increase the number of people from specific groups or people with specific needs, who require additional support from health services in order to improve their health</li> </ul>
Improving the care process i.e. better patient experience of a service and/or a more efficient service	10	We will prioritise initiatives which demonstrate or provide evidence that they are likely to demonstrate <ul style="list-style-type: none"> <li>a) good or better levels of patient satisfaction (customer feedback) and</li> <li>b) health outcomes which are as least as good as the English average</li> <li>c) efficient use of resources determined by benchmarking or other appropriate test</li> </ul>
Achievability	8	We will prioritise initiatives which it and/or its delivery partners <ul style="list-style-type: none"> <li>a) demonstrably have the capability to achieve</li> <li>b) can be fully effective within a reasonable timeframe (usually not longer than 6 months unless a major capital programme is envisaged)</li> <li>c) can provide safe services from their inception</li> </ul>
Sustainability	13	We will prioritise initiatives which can <ul style="list-style-type: none"> <li>a) demonstrate that there are no high or medium risk threats to their long term supply (5+ years)</li> <li>b) demonstrate minimum negative impact on the environment</li> </ul>

All of the proposed initiatives underwent a shortlisting process and were assessed against the criteria to calculate an overall weighted benefit score. This score was then analysed with the cost of the initiative to create a cost per benefit. The prioritisation and proposed initiatives for selection, according to the analysis, were then discussed at two Executive Management Team meetings before agreement. The selection process and the designated strategic initiatives were shared with the Professional Executive Committee, Board and practice based commissioning hubs.

### Specialised Services

It is important to note that the prioritisation of specialised services has to date adopted a different approach to our own. The North West Secure Commissioning Group (NWSCG) developed a pilot prioritisation tool for the 2008/09 Local Delivery Plan round, including review of health gain, health need, clinical and cost effectiveness as well as whether there was support from the commissioning network for the development and where it fitted in the patient pathway. We will use the 2009/10 LDP process in specialised services

to bring the prioritisation criteria of the NWSCG and our own closer together. We will also be involved, through membership of the NWSCG and the commissioning reference group, in developing the NWSCG's ethical framework for decision making.

### 4.3.2 A Focus on Improving Health

The major challenges faced by NHS Manchester in improving health and reducing health inequalities were described in Section 3. Strategic initiatives 1 to 5 specifically relate to seeking to empower communities to enjoy healthier lifestyles, while strategic initiatives 6 to 10 focus on improving the quality and accessibility of NHS care for those who are ill. Strategic initiative 11 brings together all of the key programmes to deliver better mental health.

The first two strategic initiatives relate to improving life expectancy and reducing health inequalities. These priorities are so fundamental to the role of primary care trusts that their inclusion in commissioning strategic plans is, uniquely, mandatory. Our approach is based on the six high impact changes for the NHS defined in Tackling Health Inequalities (Department of Health, 2007) and set out in figure 19. The approaches underpinning the remaining strategic initiatives are drawn from national and regional policy drivers, including High Quality Care For All and Healthier Horizons for the North West, which include a focus on personalisation,

improved access and experience, and the right to receive services of the highest quality in settings close to home.

**Figure 19 - High impact changes for the NHS to narrow health inequalities**

1. Know your age gaps in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a strong impact on the gap
2. Make smoking history – reduce smoking prevalence and target cessation services and campaigns in deprived areas and groups
3. Target prevention of cardiovascular diseases using prevalence models to identify areas of unmet need alongside a case finding strategy
4. Improve detection of cancer in local communities
5. Ensure the quantity of primary care in disadvantaged areas is sufficient to address need and is of high quality. Focus Health Trainers and Life Check programmes on tackling health inequalities
6. Empower disadvantaged communities to aspire to good health

We have looked at national modelling to see the potential of specific interventions on narrowing the life expectancy gap, as illustrated in figures 20 and 21.

**Figure 20 - Modelled interventions to reduce the gap – Standards and Quality Team and Health Inequalities Unit, Department of Health 2006**

The Interventions	The Impact – for Males		
Smoking cessation clinics		1.0%	8.9%
Secondary prevention of CVD		2.3%	
Primary prevention of CVD in hypertensives under 75 yrs			
• 40% coverage antihypertensives		1.0%	
• Statin therapy		0.7%	
Primary prevention of CVD in hypertensives 75 yrs +			11%
• 40% coverage antihypertensives		1.2%	
• Statin therapy		0.7%	
Other* including: Early detection of cancer, Respiratory diseases, Alcohol related diseases & Infant mortality (*Locally determined)		2.1%	
Universalist:			
Smoking reduction in clinics as at present		0.2%	11%
Secondary prevention of CVD 75% coverage of 35-74 yrs		1.4%	
Primary prevention of CVD in hypertensives under 75 years		0.2%	
20% coverage antihypertensive statin therapy		0.2%	





**Figure 21 - Modelled interventions to reduce the gap – Standards and Quality Team and Health Inequalities Unit, Department of Health 2006**

The Interventions	The Impact – for Females	
Smoking cessation clinics: double capacity in Spearhead areas for 2 years	1.0%	10.4%
Secondary prevention of CVD: additional 15% coverage of effective therapies in Spearhead areas 35-74 yrs	1.4%	
Primary prevention of CVD in hypertensives under 75 yrs:		
• 40% coverage antihypertensive	0.9%	
• Statin therapy	0.5%	
• Primary prevention of CVD in hypertensives 75 yrs+:		
• 40% coverage antihypertensives	3.2%	
• Statin therapy	1.6%	
• Other * including: • Early detection of cancer • Respiratory diseases • Alcohol related diseases • Infant mortality	5.6%	
<i>*Locally determined</i>		
Universalist		16%
Smoking reduction in clinics – as at present	0.4%	
Secondary prevention of CVD 75% coverage of 35-74 yrs	1.0%	
Primary prevention of CVD hypertensives under 75 yrs	0.2%	
20% coverage antihypertensive statin therapy	0.2%	

We have used the National Health Inequalities Intervention Tool to model the impact of our plans for helping more people to stop smoking, which are embedded in the first strategic initiative, on inequalities between the most deprived areas of Manchester and the city as a whole. This analysis suggests that a 50% increase in the number of people successfully quitting after 4 weeks (from around 4,400 to around 6,600 quitters a year) would have the effect of narrowing the gap between the most deprived quintile and Manchester as a whole from 4.0% to 3.9% for men and from 2.2% to 2.1% for women (a fall of 3.2% and 6.5%).

We know that we will also need to work in partnership to address the wider determinants of health such as poverty, employment, poor housing, poor educational attainment and to improve aspirations and well-being. Much of this work will be led by the Manchester Partnership, the local strategic partnership of which NHS Manchester is an active member, which has a vision for a world class city by 2015 where people will live longer, be wealthier and happier (Manchester Community Strategy 2006-15). The priorities of the Community Strategy are reflected in the new Local Area Agreement, which includes the outcomes for our first five priorities. We will also be working with the Manchester City Council to implement the high impact changes for local government, which are shown in figure 22.

**Figure 22 - High impact changes for local government to narrow health inequalities**

1. Know your gaps in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a sufficient impact.
2. Maximise use of Local Area Agreements and other local plans to focus on health inequalities
3. Local Authority Scrutiny Committees – use their powers to reduce health inequalities
4. Focus Health Trainers and Life Check programmes on tackling health inequalities
5. The duty of wellbeing enables local authorities to improve the quality of life, opportunity and health of their local communities
6. Empower disadvantaged communities to aspire to good health

The strategic initiatives to achieve goals 3, 4 and 5 are based on national best evidence for alcohol interventions (NTA) and recommendations from visits to Manchester by National Support Teams for Teenage Pregnancy and Childhood Obesity.

We will be implementing all of the initiatives systematically and at the industrial scale recommended by the National Support Team for Health Inequalities. The recent publication of the Health Inequalities self assessment framework by NHS North West has also confirmed that these actions are the ones needed to improve life expectancy and reduce health inequalities in Manchester.

### 4.3.3 Overview of Strategic Initiatives

The strategic initiatives we have selected to support and achieve our goals are set out in brief summary form over the next few pages and at figure 23. The full descriptions of each are set out in appendix 4. Each initiative contains a suite of programmes designed to achieve the designated outcomes.

#### Strategic Initiatives 1 and 2 – Help people live longer and reduce the gap in health between different communities

The strategic initiatives for Priorities 1 and 2 are combined. We believe that to increase life expectancy and reduce health inequalities there must be a focus on the causes of ill health and empowering communities to lead healthier lives with the support of effective local health services. The strategic initiative includes six work programmes:

- Implementing best practice guidelines for reducing smoking in pregnancy and increasing breastfeeding;
- Tobacco Free Communities programme;
- Cardiovascular disease risk assessment and management;
- Improved prevention and early diagnosis of cancer;
- Healthy living networks; and
- Health trainers.

#### Strategic Initiative 3 – Reduce the number of teenage conceptions

The strategic initiative for Priority 3 has three main elements:

- Clinical outreach in those wards with highest rates of conception among under-18s;
- A prevention team to work on a targeted basis with young women who may become pregnant at an early age; and
- Teenage Pregnancy Programme.

#### Strategic Initiative 4 – Reduce the number of alcohol-related hospital admissions

The strategic initiative for Priority 4 will establish alcohol screening programmes and brief intervention projects in the 3 Manchester A&E departments and within primary care. The

Figure 23: Strategic Initiatives summary



programme will ensure that problem drinkers have access to early intervention at key points of access to healthcare and that heavy/dependent drinkers attending A&E will be provided with timely support to prevent readmission.

### **Strategic Initiative 5 – Reduce the number of children who are overweight**

The strategic initiative for Priority 5 has three programmes:

- Breastfeeding Peer Support Service (this also contributes to strategic initiative 1 and 2);
- Family centred lifestyle support for the under 5s, including the training of Early Years workers to work with families in supporting healthy lifestyles for the whole family; and
- Community Food Workforce expansion to address exercise/activity on referral, increased capacity in leisure services provision and an Early Years prevention programme around healthy weight which links with the Child Health Promotion Plan.

### **Strategic Initiative 6 – Make sure health services are safe**

The strategic initiative for Priority 6 has five main elements:

- Build capability to deal with adverse clinical events;
- Implement best practice trigger tool analysis;
- Prevent 'Never Events';
- Resource patient safety; and
- Expand and reconfigure the community infection control team.

### **Strategic Initiative 7 – Improve the quality and availability of primary care services**

There are six main elements to the strategic initiative for Priority 7:

- Procurement of additional GP practices;
- Procurement of a GP-led health centre;
- Procurement of additional dental services;
- Procurement of extended GP opening hours;
- Reducing demand and streamlining patient access; and
- Developing the Manchester Standard as a new quality mark for primary care services.

### **Strategic Initiative 8 – Make sure patients with a long term condition have a personalised care plan**

The strategic initiative for Priority 8 has three programmes:

- Implementation of personal care plans for patients with

chronic obstructive pulmonary disease;

- Implementation of personal care plans for diabetes patients from black and minority ethnic communities; and
- Personalised budgets for self care long term conditions.

### **Strategic Initiative 9 – Improve access to planned care**

There are six main elements in our strategic initiative for Priority 9:

- Mobilising five new Clinical Assessment Treatment and Support Services (CATS) as part of a Greater Manchester-wide initiative and a further three local CATS for a number of clinical pathways;
- Working with existing providers to review and redefine existing Tier 2 services;
- Ensuring capacity gaps are identified annually and that alternative providers are commissioned to meet the shortfall;
- Working to enable GPs to access diagnostics directly to support patient management within primary care;
- Continuing to work with practice based commissioners on developing and implementing new initiatives for better access; and
- Working with secondary care to determine the best use of resources.

### **Strategic Initiative 10 – Improve access to urgent care**

The strategic initiative for Priority 10 comprises three programmes:

- System reform of urgent care;
- Managing urgent care demand; and
- Increasing the capacity and effectiveness of community services.

### **Strategic Initiative 11 – Mental health**

This is a cross-cutting initiative with links to many of those in previous initiatives. It summarises our whole system approach to improving mental health and mental health services.

Appendix 4 provides a comprehensive overview of each strategic initiative including:

- How the initiative supports our goals;
- Anticipated impact on health inequalities and outcomes;
- Activity and finance;
- Investment and disinvestment required;

- Stakeholder engagement in the formation of the initiative;
- Capabilities for delivering the initiative; and
- Implementation risks.

## Risk Management

NHS Manchester has rigorous risk management and governance processes that are subject to a high degree of internal and external scrutiny from the Board, internal and external auditors and the Healthcare Commission. These processes will be applied to the delivery of this plan. For each of our strategic initiatives, a risk assessment has been conducted to outline the specific risks, the level of risk and specific actions to mitigate and

reduce the risks to an acceptable level. These assessments are detailed in appendix 4.

In addition, there are a number of higher level generic risks associated with the successful implementation of the plan, as detailed below.

From this table our top two risks appear to be;

- Delivery of financial savings profile; and
- The reputation of NHS Manchester.

These risks will be included in our strategic risk register.

Risk	Severity	Likelihood	Score	Mitigating Action
Our commissioning capacity to support delivery.	5 Very high	2 Low	10	Constant review of capacity to deliver. Enhancements to capacity to be considered. Use of external resources if necessary
Programme management system not developed sufficiently to deliver plan	4 High	3 Medium	12	Development of programme management practices and performance; review process around delivery
Lack of buy-in to the plan by key stakeholders	4 High	2 Low	8	Build on the strong engagement in preparing the plan by extensively sharing and engaging stakeholders in finalising and implementing the plan; make full use of existing strong mechanisms such as the Manchester Partnership, the LINK, joint commissioning and Director-level team to team meetings
Deliverability of the financial savings profile associated with the plan	5 Very High	3 Medium	15	Programme management to monitor the delivery of savings by ensuring that delivery programmes have well developed implementation plans and system reform
Pressures in 2009/10 and beyond (financial and demand) exceed planning assumptions	4 High	3 Medium	12	Initiative timing and profiling to be reviewed to reflect available resources; system reform and development of contracting management process, e.g. coding, and resource utilisation
Insufficient co-ordination of health improvement interventions within the strategic partnership plans for tackling the wider determinants of health	4 High	3 Medium	12	Implementation of effective partnership delivery through joint planning and execution processes; incorporation of programme management practices with all projects and the utilisation of the Joint Health Unit for capability assessment
Acceptability of the total return programme to partners and the public	3 Medium	3 Medium	9	Ensure thorough engagement with stakeholders; present a clear case for disinvestment, with benefits and dis-benefits clearly articulated; use Talking Health to continue ongoing dialogue with stakeholders



Risk	Severity	Likelihood	Score	Mitigating Action
Providers unable to make the necessary changes to culture, behaviour and service delivery	4 High	2 Low	8	Work closely with other commissioners to influence provider response; seek external market solutions if necessary to develop a broader reform programme
Reputation management of NHS Manchester	5 Very High	3 Medium	15	Develop our risk management processes as part of our Wold Class Commissioning performance agenda
Slow progress on the deliverability of our Organisational Development (OD) plan	3 Medium	3 Medium	9	Apply programme management to the OD implementation plan

Scale – 1 (very low) to 5 (very high)

## 4.4 Summary of Overall Impact

This section describes the overall impact of our strategic initiatives on our population health, activity and finance, and the implications for provider landscape.

### 4.4.1 Impact on Population Health and Health Inequalities

Improving health and reducing inequalities in Manchester is by nature complex and multifactorial; involving numerous agencies within health and local authorities. As discussed in the document, our contribution consists of a suite of programmes that focus on our priorities. Figure 24 demonstrates that a number of these programmes will also impact on other priorities.

**Figure 24 - Summary of overall impact on Goals**

Objectives	Priorities	Goals	Initiatives	Also impact on
Inequalities, aspiration and wellbeing	Help people to live longer	To increase the average life expectancy of Manchester residents to 80 yrs	Reduce infant mortality Tobacco Control Cardiovascular disease management and prevention Improve detection of cancer Healthy living networks Health trainers	Urgent care (CVD and smoking) Planned care (Cancer)
	Reduce the gap in health between different communities	To ensure that the city is no longer among the top 5 most deprived local authorities in England	Combined with above	

Objectives	Priorities	Goals	Initiatives	Also impact on
Inequalities, aspiration and wellbeing	Reduce the number of teenage conceptions	To reduce the under-18 conception rate by 55% from the 1998 baseline	Clinical outreach in hotspot wards Prevention team Teenage Pregnancy Programme	Life expectancy Health inequalities
	Reduce the number of alcohol-related hospital admissions	To halt the expected rate of growth in alcohol-related admissions	Integrating alcohol screening and brief intervention in primary care and Accident and Emergency, and improving care pathways for people with alcohol problems	Life expectancy Health inequalities Unplanned care
	Reduce the number of children who are overweight	To reduce and sustain a reduction in levels of childhood obesity	Breastfeeding Peer Support Service Family centred lifestyle support for the under 5s Community Food Workforce expansion	Life expectancy
Safe and effective services	Make sure health services are safe	To reduce and sustain the number of C Difficile infections by 45% in line with national targets	Build capability to deal with Adverse Clinical Events Implementing best practice Preventing never events Resourcing patient safety Expand and reconfigure Community Infection Control Team	Unplanned care Life expectancy
	Improve the quality and availability of primary care services	To increase the percentage of practices offering extended opening, in compliance with Department of Health guidelines	Procurement of GP practices and NHS dental services Extended GP hours Reducing demand and streamlining patient access Developing the Manchester Standard	Unplanned care Planned care Health inequalities
Accessible, personalised services	Make sure patients with a long term condition have a personalised care plan	To ensure that all people with long-term-conditions are supported to be independent and in control of their condition maintained by personalised care plans.	Implementation of Personal Care Plans for patients with: <ul style="list-style-type: none"> <li>Chronic obstructive pulmonary disease (COPD)</li> <li>Diabetes (for patients from black and minority ethnic groups)</li> <li>Mental Health problems</li> <li>Self care long term conditions</li> </ul> Redesign of Crisis Resolution Home Treatment	Life expectancy Health inequalities Planned care Unplanned care
	Improve access to planned care	To ensure that 90% of admitted and 95% of non-admitted patients are seen within 18 weeks (at each provider in each month)	5 new Clinical Assessment, Treatment and Support (CATS) commissioned jointly by Greater Manchester PCTs 3 CATS commissioned by NHS Manchester Redefine outpatient services Cover capacity shortfalls Practice Based Commissioning initiatives Waiting time in community care 18 weeks access to psychological care	Unplanned Care Health inequalities





Objectives	Priorities	Goals	Initiatives	Also impact on
Accessible, personalised services	Improve access to urgent care	To ensure that at least 98% of patients spend less than 4 hours in A&E (at each provider in each month)	System reform of urgent care Managing urgent care demand Increasing capacity and effectiveness in the community	Planned care
	Mental Health	To ensure that all people with long-term-conditions (LTCs) are supported to be independent and in control of their condition maintained by personalised care plans.	Health Trainers/Healthy living network Alcohol brief-interventions Redesign Crisis Resolution Home Treatment Teams Access to Psychological Therapies	Avoidable harm Un/ Planned Care Personal Care Plans

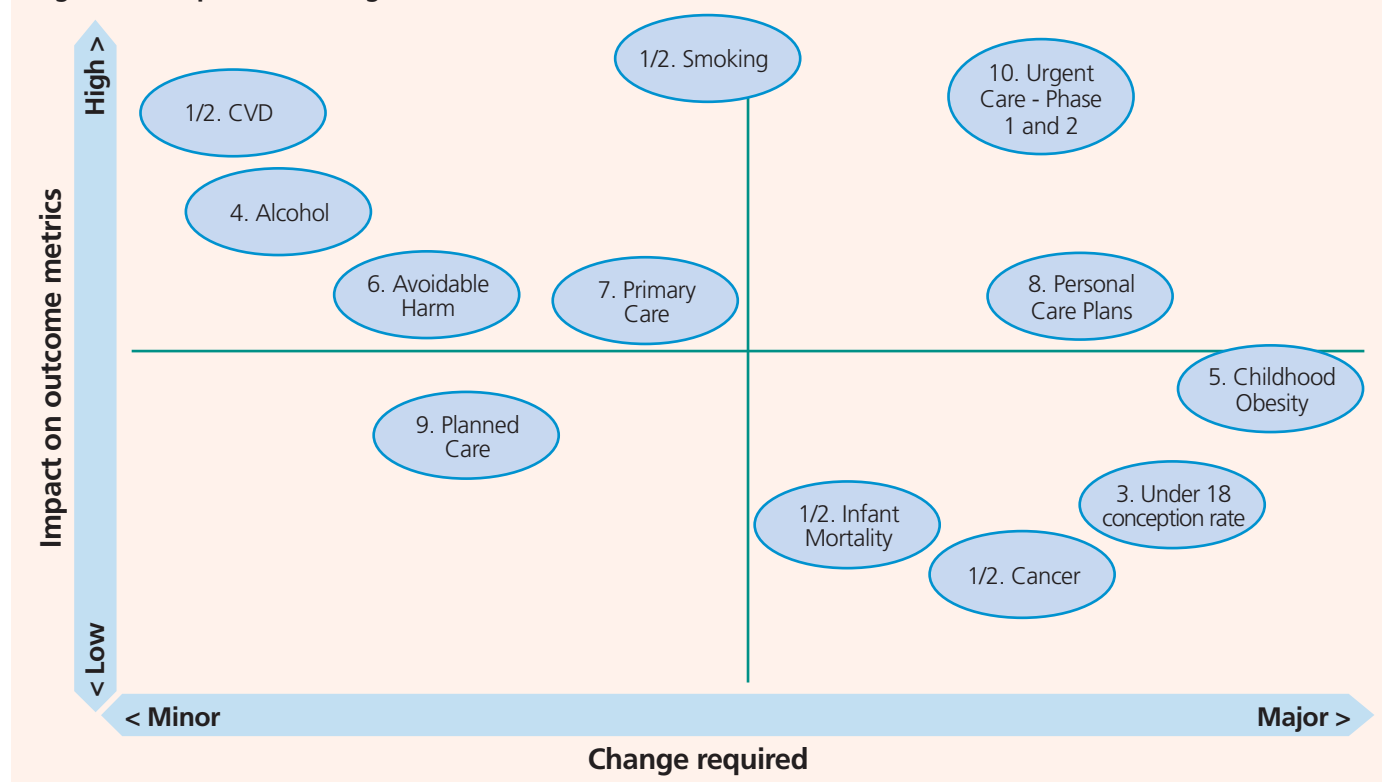
#### 4.4.2 Implications for Provider Landscape

In order to understand the impact on outcomes and the change required we have undertaken an impact assessment, illustrated in Figure 25 below.

From this assessment we have identified that the areas of high impact and relative short term change required (1-2 years) would be:

- A cardiovascular disease initiative within the first 18 months, which evidence indicates would have a potential sizable benefit in increasing life expectancy and reducing health inequalities. There could potentially be a change in providers' role with pharmacies bidding for contracts, with potential disinvestment for the acute sector and greater use of the third sector;

**Figure 25 - Impact and change assessment matrix**



- Initiatives to reduce the increase in the rate alcohol-related admissions, which would impact significantly on female life expectancy while having a short term impact win on reducing activity in the acute sector as interventions in primary care are developed. Overall it would not have a major impact on emergency admissions but achieve a high impact on the chosen outcome metric;
- Initiatives to reduce avoidable harm can realise short term improvement; and
- Improvements to access in primary care could have short term benefits while providing a foundation for system reform in urgent care.

The initiatives with potentially high impact that require longer term significant change are:

- A major transformation programme in urgent care. The productivity gains show that the overall spending on urgent care will be £3 million, which is above average. The work to fully define this initiative and costs more clearly is currently only at a scoping stage;
- Stopping smoking, which national and local evidence indicates can have the largest single impact on life expectancy and improving health status medium term; and
- Developing personal care plans for patients with long term conditions, which will require leadership from practice based commissioners and the design and procurement of new services.

Rapid progress with minimal change required could be achieved in:

- Initiatives around planned care, which largely build on existing programmes.

A significant number of the health improvement initiatives will require more time to be implemented as there will need to be work with other local partners to change the determinants of health inequalities. Specifically in relation to cancer, there will be a focus on trying to improve outcomes by increasing earlier interventions rather than potential for disinvestment.

The healthcare market in Manchester has traditionally been centred on acute care and hence hospital based. The strategic initiatives are a twin track approach:

- targeted investment on key services; and

- transfer of resources away from acute and hospital-based and towards community-based and primary care services.

The headline impact on the provider landscape for current secondary care supply is one of disinvestment and pressure to increase efficiency. Within this there is also, for instance via the initiative to increase planned care access, the opportunity to transfer secondary care focus and resource into new, community-based market opportunities, such as CATS.

The headline impact for the community health economy is one of expansion via investment and pressure to increase efficiency. The aim for community health services to streamline delivery model provides a double opportunity to the health system. Via the level of efficiency available, community healthcare can self-fund investments and deliver cash releasing savings for investment in the wider economy. This double opportunity also exists within the mental health sector, as indicated by the programme budgeting analysis earlier in this plan that places mental health in the 'high spend, worse outcomes' category.

For primary care, the impact on the provider landscape is one of threefold expansion:

- improving current supplier-stock;
- commissioning into new provision; and
- developing new markets.

For example, the primary care access initiative will impact significantly on supply side the number of GP practices, expand the hours available for current practices to deliver services, increase opportunities within the pharmacy sector and add capacity to the primary care dental sector.

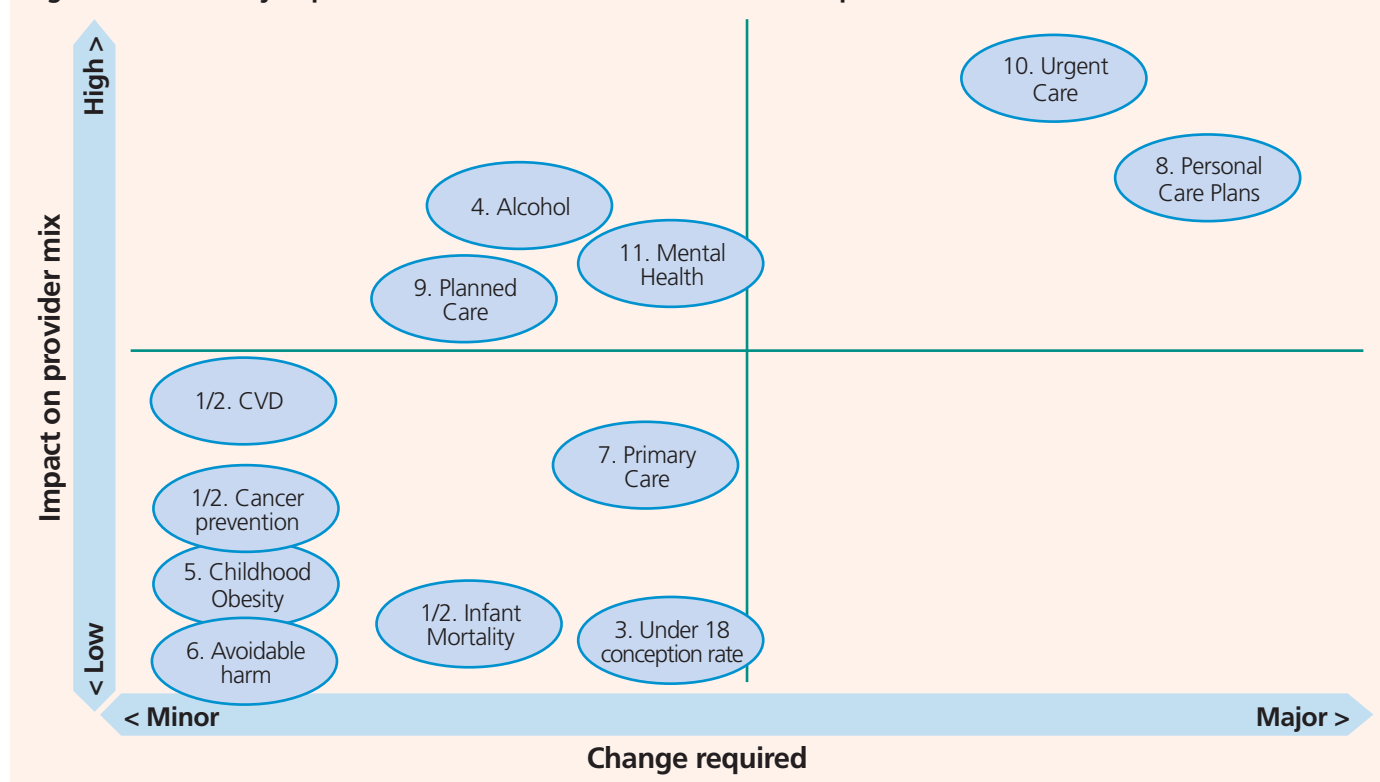
We have commenced work with Manchester Metropolitan University's Business School to produce a full market analysis of the Manchester health economy and assessment of the market state of provider service/market segments.

The first stage of this is underway and comprises a full analysis of our strengths and opportunities under each sub-category within Porter's 5-Forces model. This assessment will then be developed in to action plans for delivery.

Reducing market entry barriers is a key consideration of our market development strategy. For example, the provision of suitable estate to potential new providers is being considered through the Manchester Science Park and the Manchester City South Project.



Figure 26 - Summary impact assessment on Future Provider Landscape



We have undertaken an overview of the impact of each strategic initiative on the provider landscape, by examining opportunities for changing the provider mix and scale of change. This assessment is illustrated in figure 26.

We consider our largest opportunities depicted in the high impact segments, both from a medium and short term perspective are associated with the following;

- the proposed commissioning of alternative mental health service packages around home treatment based services and personal care plan packages for patients with schizophrenia;
- elements of our future urgent care service network in a community and primary care setting;
- interventional health improvement programmes targeted at particular neighbourhoods areas covering our strategic initiatives around CVD and smoking cessation; and
- development of our personal care packages for specific patients with long terms conditions, plus the design and delivery of self care plans outlined in strategic initiatives.

It is our intention to pursue specific market making opportunities in targeted areas where measurable health

gains can be delivered. This delivery programme will be supported by our planned organisation development programme around World Class Commissioning Competency 7 – Stimulating the markets.

Our strategic initiative 9 around improving further our access to planned care will continue to provide market and provider development opportunities through the proposed collaborative commissioning initiatives of the five new Clinical Assessment Treatment and Support services and our plans to improve pathways in the areas of ophthalmology, dermatology and dental services.

We will also consider market making opportunities to deliver our planned minimum waiting times for specific community services and providing sufficient capacity and choice in the system.

Urgent care reform provides a major opportunity to explore new provider solutions to strengthen our capability to deliver the proposed reforms. This will potentially change the provider relationship and need for joint multi-provider working within an urgent care network.

### Developing new solutions – Public health initiatives

Market development projects to support public health

initiatives are also already underway, including the Points4Life programme. This is a loyalty scheme that will use the retail and leisure industry market to reward healthy lifestyle choices, such as taking up exercise or switching from white to wholemeal bread. We will develop this market by using already established retail and leisure outlets, such as local stores and leisure facilities to operate and fund the programme and promote the healthy lifestyle message. In partnership with the city council we are bidding for support for this work via the Healthy Cities programme. Points4Life will target the most deprived areas of Manchester, thereby supporting the target to reduce the gap in health between different communities and also help Manchester people in general to live longer.

This programme seeks to enhance current delivery of physical exercise support services and increase the number of providers to generate vibrant competition and increase market coverage. This market development is targeted at helping people live longer (strategic initiative 1 and 2) and reduce the number of children who are overweight (strategic initiative 5).

We have already applied innovative style market development

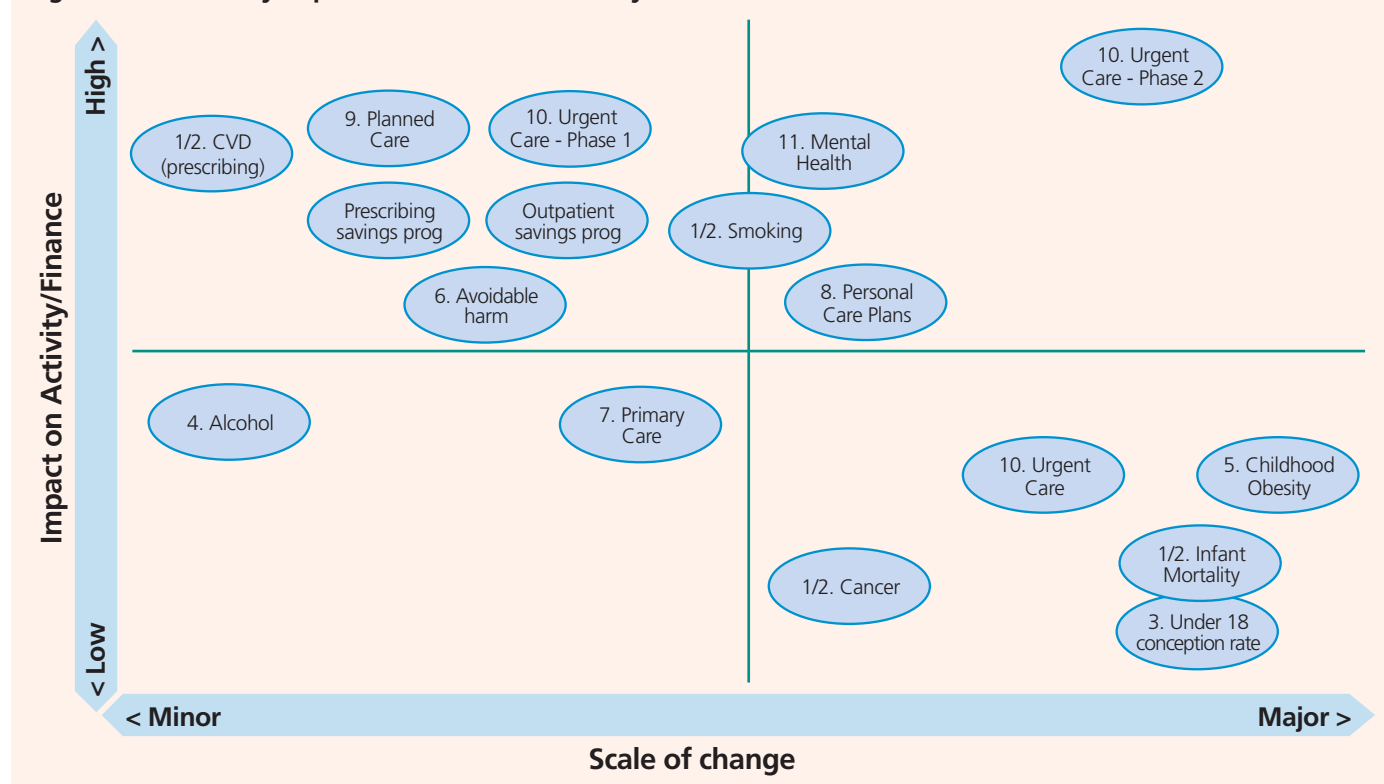
techniques such as Prior Indication Notice system to engage with potential market entrants in the design phase of commissioning models. This process has already been used to beneficial effect in our ongoing review of urgent care in central Manchester, attracting design stage engagement from the third and the independent sector.

### 4.4.3 Activity and Finance

A significant number of our proposed initiatives are projected to impact on our existing secondary care and primary care providers through the following proposed commissioning changes.

- Reductions in A&E attendances through our planned initiatives around personal care plans and urgent care plans;
- Reductions in the scale of emergency admissions projected through our general health improvement interventions, urgent care and financial improvement programmes;
- Reductions in hospital stays through urgent care system reforms and personal care plan initiative; and

**Figure 27 - Summary impact assessment on Activity/Finance**



- Reductions in the scale of hospital based outpatient interventions through improved care resource utilisation initiatives and our changes to commissioning of planned care.

As a health community, we still have major significant variances from upper quartile levels of performance as depicted in the national Better Care Better Value indicators, particularly in the areas of outpatients, emergency admissions and primary care prescribing. We intend to rigorously pursue improvement programmes in these areas.

In areas of tertiary services, through our specialised commissioning arrangements there will be various areas of potential service growth as a result of enhanced screening and earlier intervention programmes, particularly in relation to cancers. Our assessment of the potential impact of our strategic initiatives and supporting savings programmes is summarised by figure 27 on previous page.

In order to finance the investment programme our delivery programme needs to drive through the changes required in improving our resource utilisation in the following areas. The expected largest impact areas with potential short term delivery timescales (1-2 years) are:

- Reducing the levels of emergency admissions (urgent care networks);
- Reducing the scale of hospital-based outpatient attendances (planned care); and
- Reducing prescribing costs in targeted areas to national norms (NHS Manchester currently has a lower than average performance against the national average for low cost statin prescribing and other prescribing benchmarks).

The delivery programme will also focus on what is needed to deliver the high impact initiatives requiring medium change, namely around:

- Planned care;
- Cardiovascular disease and related prescribing;
- Urgent care - phase 1;
- Prescribing savings programme; and
- Outpatients savings programme.

## 4.5 Affordability

Our plan is underpinned by a financial plan which is available as a separate document. This section summarises the assumptions on which the affordability of the plan is based and confirms, at a high level, actions that will be undertaken to achieve affordability over its 5-year lifespan.

We have designed a number of strategic initiatives that focus on achieving the health improvement and reduction in health inequalities results that are required. Considerable work has been undertaken to establish the evidence base both for the efficacy of the measures planned and the cost and savings profiles relating to each of the initiatives. However, implementation of these initiatives will not be sufficient in themselves to keep NHS Manchester in recurring financial balance. Therefore we will also develop a systems reform programme to drive out the substantial savings that are required in a number of areas identified from programme budgeting and other analyses

In summary, in order to fund our strategic initiatives and to finance cost pressures (eg demographic changes) we need to achieve savings of £56.5m (as detailed in Figure 28) and these will be derived from a combination of the strategic initiatives, improving resource utilisation and other system reform programs over the next 5 years.

### 4.5.1 Overall Affordability

Figure 29 demonstrates the gross and net costs of each of the strategic initiatives. The detail behind each initiative illustrates how these costs have been assessed, together with the associated impacts on activity. However, as is clear from the table, the overall cost of the strategic initiatives is greater than the savings they generate. Compensating savings will be generated as follows.

### 4.5.2 Improving our Resource Utilisation

We also have other investment requirements associated with mandatory cost pressures and other cost pressures, such as additional activity through demographic change, that are forecast to arise over the 5 year period. This will need to be financed through additional savings programmes and the application of future funding growth. Our financial plan projections indicate that we will require a further £30.6m savings to be realised over the 5 year period.

Figure 29 shows a summary of the proposed financing of this additional investment requirements and the indicative

targets set for the planned system reform and improving our resource usage savings programme.

define this in more detail, within our future operational planning process.

The principle we will adopt is to match the pace of investment to the realisation of savings. Further work will

**Figure 28 - Source of Funds**

Source of funds	Savings identified 2012/13 £000's
Strategic initiatives savings	25,985
Improving our resource utilisation	10,600
System Reform	20,000
Sub Total	56,585

**Figure 29 - Gross and net costs of strategic initiatives**

	Costs 2012/13 £000's	Savings identified 2012/13 £000's	Net 2012/13 £000's
1. Help people to live longer	5,909	3,003	2,906
2. Reduce the gap in health between different communities	0	0	0
3. Reduce the number of teenage conceptions	279	335	-56
4. Reduce the number of alcohol-related hospital admissions	660	621	39
5. Reduce the number of children who are overweight	542	0	542
6. Make sure health services are safe	567	734	-167
7. Improve the quality and availability of primary care services	7,910	550	7,360
8. Make sure patients with a long term condition have a personalised care plan	1,900	6,467	-4,567
9. Improve access to planned care	4,750	4,098	652
10. Improve access to urgent care	4,468	10,177	-5,709
11. Mental health *	n/a	n/a	n/a
Sub Total	26,985	25,985	1,000

\* Costs and savings for the strategic initiative on mental health are embedded in those for the other strategic initiatives.

**Figure 30 - Improving our resource utilisation savings targets**

Improving our resource utilisation	Savings identified 2012/13 £000's
Efficient, Streamlined Providers	2,500
Non traiff	1,500
Coding	1,000
Productivity gains	2,600
Prescribing	3,000
Sub Total	10,600





### 4.5.3 Efficient, Streamlined Providers

We anticipate generating at least £2m from stimulating efficiencies within providers over and above the 3% efficiency that they must deliver. Detailed plans will be developed as part of the operational plan and further evidence will be sought to enable more robust estimates of savings to be made. The focus will be on three main areas:

- Continuing care services will be more effectively commissioned and contracted for, to reduce the frequency of providers achieving premiums at the expense of NHS Manchester's funds by undue reliance on spot contracts, insufficient contracting infrastructure and 'muscle' and weak contract terms;
- Services which are identified under programme budgeting to be high consumers of resources with low associated outcomes or where productivity opportunities have been identified via the Better Care Better Value indicators will be systematically challenged to improve resource utilisation and improve outcomes. While this challenge process will result in shifts of investment within programmes, typically from acute to primary and community care, it will also be expected to generate cash releasing efficiency gains which will be returned to NHS Manchester; and
- Additional, as yet uncoded savings may be achieved from the opportunity costs in non-elective care and outpatient activity referred to earlier. Further detailed work is needed to understand the potential impact.

### 4.5.4 Improving Coding

Clinical coding is an essential underpinning process for NHS business as it is the basis on which charging under payment by results (PbR) occurs. In its most recent study of clinical coding errors in the NHS, the Audit Commission (PbR Data Assurance Framework 2007/08, August 2008) identified an average financial error of 9.4 per cent linked to poor coding quality. There was a range across trusts from 0.3% to 52%. These errors contributed to a gross financial error of approximately £3.5 million, approximately 5 per cent of the price of the sample reviewed. Although the Audit Commission found that in most cases the net financial impact of the errors was close to zero, there were a number of cases where the net financial impact of errors was significant.

As part of our efficiency programme we will seek to improve clinical coding quality across the health community primarily through joint audit processes. We anticipate, on the basis of pilot work and sampling to date, being able to recover £1m from PbR services. This total does not include potential savings from specialist services which it is expected will be subject to a separate data quality improvement process.

### 4.5.5 Improving Costs within Non-Tariff Services

Non-tariff services will be subject to efficiency programmes in a number of ways; mental health services will be affected by work around programme budgeting and community health services will be affected by the drive to reduce reference costs. However, we have identified other, separate opportunities for cash releasing efficiency gains from non-tariff services. There are two main areas in which cash releasing gains are anticipated:

- Primary care contractors will be expected to contribute to our efficiency programme not only through service redesign but also through skill-mixing and reducing prescribing costs; and
- There are cost efficiencies to be gained from improving the efficiency of individual treatments and placements (for example, some of those made through our process for effective use of resources) by improving contracting effectiveness and reducing reliance on spot purchases.

These two areas are expected to generate a further £1m of savings.

### 4.5.6 System Reform

In order to fund costs pressures we will introduce a programme of System Reform. A summary of the programme budgeting (see appendix 2) work identifies that there is considerable scope for major cost savings to be achieved. This is summarised below

- Respiratory problems - £18m
- Maternity and reproductive health - £12m
- Circulatory problems - £12m
- Neurological problems - £8m
- Infectious diseases - £6m

We have already initiated a programme to improve outcomes in diseases of the circulatory system and anticipate reductions

in costs to be achieved as patients are identified earlier in the disease cycle. COPD services are also in development and again it is anticipated that major improvement can be achieved in managing patients effectively outside of hospital and thus make savings on hospital costs. The plans for a City-wide Healthy Living Network, which is expected to be approved by the Board in November 2008, will also aim to achieve greater levels of engagement with communities with poorer health and in so doing enable screening programmes/ early intervention for cancer, CVD and lung diseases to become more effective. NHS Manchester also spends around 17% of its allocation on outpatient services and we feel that this sum could be considerably reduced both by adopting national norms for follow-up attendances and reforming the process overall to give GPs a larger role in discharging patients from treatment pathways.

We need to achieve savings of £20m from the systems reform programme over the five year period. As can be seen from this list above, there is plenty of scope for major cost savings to be achieved

We will need to invest significant resources in the important area of system reform and develop the relevant organisational competences to enable these cost savings to be achieved.

#### 4.5.7 Summary of Affordability

Overall, taking the 5 year perspective, we are currently proposing an investment programme on the strategic initiatives of £27m with a targeted savings programme of £26m. Cost pressures will be financed through our proposed system reform and improving resource utilisation programmes.

The principle we will adopt is to match the pace of investment to the realisation of savings. Further work will define this in more detail, within our future operational planning process.



# 5. Delivery

Implementing this plan will now become our main priority as a commissioner. To deliver it effectively we must learn from past experiences, build on best practice where it exists and develop new ways of working where they are needed to achieve transformational change. A number of themes will underpin our approach to realising the aims set out in this document, the implementation of which will be supported by the Operational Plan and Organisational Development Plan. This section explores how we will deliver what we are setting out to achieve.

## 5.1 An assessment of past delivery performance

NHS Manchester has demonstrated a recent track record of delivery in the following key areas:

1. Improving the population's health
2. Development of clinical care pathways
3. Improving our contractual and performance management
4. Improving our financial management

We outline below some examples of our recent delivery and the key reasons for the success, alongside identification of areas for improvement.

### Improving the population's health

#### Smoking Cessation

We have exceeded our targets on smoking cessation through the adoption of larger scale targeted intervention programmes.

We believe our track record on the design and delivery of effective health improvement interventions has improved significantly over the last two years. Our recent achievements are:

- 99% compliance rate with the new smoking legislation, for pubs and clubs, in the first 6-months of implementation;
- Initiation of 14 additional drop-in stop smoking services to help cope with demand from local communities;
- training a further 285 professionals to intermediate level

status (total of 1,513 intermediates now trained);

- a quit rate of 43% supporting 9,424 smokers who set quit dates with many accessing the Nicotine Replacement Voucher Scheme;
- a fall in smoking prevalence in pregnancy of 4% to 19%;
- 1,943 Manchester homes now registered on the Manchester Smokefree Homes Scheme, with 31% making a behaviour change to offer protection from second hand smoke for the youngest and most vulnerable within the community; and
- 120 primary schools received smoking prevention support through the "Smoke Free City" scheme.

The success of this work to date has included:

- Effective partnership working with our local council partners; and
- Application of our health equity audits to target specific gaps; and
- Developing our workforce to provide capacity and capability to tackle health inequalities.

#### Development of clinical care pathways

Some of our key success stories are associated with the development of chronic obstructive pulmonary disease (COPD) pathways in north Manchester. We have redesigned the whole pathway and improved accessibility to services for the targeted population in north Manchester. This work has resulted in the development of enhanced patient-focused services and extension of services in a community setting that avoids hospital admissions and enables early screening for the disease. This has been achieved through:

- A multi-organisational/service leads stakeholder design and planning group;
- The translation of the service needs into commissioning intentions; and
- The development of revised provider-based contracts to focus on the delivery of the new care pathways.

It is our intention to extend this COPD care pathway to other areas of Manchester and continue to develop strategic commissioning on a whole pathway basis across the city



Another successful care pathway initiative is the improvement in our sexual health pathways through the use of community pharmacists. The key success stories to date are:

- Improved accessibility of screening services to young people, e.g. Manchester achieved one of the highest rates of Chlamydia testing in 2007/08;
- The development of commissioned minimum services standards expected; and
- Extended role development of community pharmacists and planned roll out.

This again has demonstrated of what can be achieved through the application of several World Class Commissioning competencies around the engagement of multi-sector agencies, effective design planning processes and the translation of service specifications into commissioning contracts.

### Improving our contractual and performance management

We have also started to improve our commissioning and contracting approach with our mental health providers. The recent key achievements include:

- Establishment of a single contracting team and process;
- Development of a joint system wide performance assessment framework; and
- Progress with implementation of the national model contract.

We intend to build upon this improved commissioning position by developing our programme management approach to the implementation of the Boyington report's key recommendations.

Contracting and performance management of acute trusts has challenged counting and coding of activity which has been validated and challenged where necessary. These challenges have recovered hundreds of thousands of pounds. In addition to this clinical requirements have been set around consultant to consultant referrals, timeliness of discharge letters and outpatient follow up ratios have been introduced. These have led to improvements to patient care and prospectively saved significant resources through reduced activity with improved care pathways and reduced acute care costs .

## Financial Management

We have significantly improved our financial management practices over the last two years from the inherited legacy of the three previous primary care trusts. We achieved financial balance in 2007/08, with the delivery of a small surplus, and are projecting a similar position in 2008/09. In developing our World Class Commissioning competencies, we recognise our development needs within improved investment planning and implementation tracking. In addition, we propose to improve our financial reporting and contract management and validation processes, for example data coding and resource utilisation reviews.

## 5.2 Key Themes for Delivery

As a learning organisation our past performance has provided us with some valuable lessons that will support us in going forward and help identify areas on which we must focus to ensure successful delivery of this strategy. The key themes are as follows.

### 5.2.1 Implementing system reform

We have designed the strategic initiatives set out earlier with a focus on achieving better health and a reduction in health inequalities. Considerable work has been undertaken to establish the evidence base both for the efficacy of the measures planned and the cost and savings profiles relating to each of the initiatives. However, implementation of these initiatives will not be sufficient in itself to keep the organisation in recurring financial balance. We have developed a system reform programme to drive out the substantial savings that are required in a number of areas identified from programme budgeting and other analyses. As highlighted earlier, this information suggests that we have higher than average equivalent costs in the following areas:

- Mental Health - £22m
- Problems of the respiratory system - £18m
- Maternity and reproductive health - £12m
- Problems of the circulation - £12m
- Neurological - £8m
- Infectious diseases - £6m

A programme to improve outcomes in diseases of the circulatory system has already been initiated and anticipates reductions in costs to be achieved as patients are identified earlier in the disease cycle. Chronic obstructive pulmonary disease services are also in development and again it is



anticipated that major improvement can be achieved in managing patients effectively outside of hospital and thus make savings on hospital costs.

The plans for a city-wide Healthy Living Network, which is expected to be approved by the NHS Manchester Board in November 2008, will also aim to achieve greater levels of engagement with communities with poorer health and in so doing enable screening programmes and/or early intervention for cancer, cardiovascular disease and lung diseases to become more effective.

Meanwhile we spend around 17% of our allocation on outpatient services and feel that this sum could be considerably reduced both by adopting national norms for follow-up attendances and reforming the process overall to give GPs a larger role in discharging patients from treatment pathways.

## 5.2.2 Programme Management

This plan requires the delivery of a complex set of programmes, which are linked and interdependent. It presents a very challenging agenda in a changing and complex environment. We are proposing that we will implement programme management techniques to manage and best deliver the outcomes of this plan.

A programme is a portfolio of projects and activities that are co-ordinated and managed in such a way that they achieve outcomes and realise benefits of strategic importance. We recognise the attributes of a successful programme as being:

- A clear and consistent vision of the outcome;
- A focus on benefits and threats to their achievement;
- Coordination of a number of projects and their interdependencies; and
- Leadership, influence and management of the transition.

We are seeking to develop the core components of a programme management system that comprises:

- Organisation and leadership;
- Benefits management;
- Stakeholder management and communication;
- Risk management and issue resolution; and
- Programme planning and control.

In order to turn this plan into reality, we will establish strategic initiative-based delivery teams to drive implementation with a robust assurance framework. The management of risk is central to effective programme management; therefore each delivery team has described the key risks associated with the implementation of each strategic initiative which are summarised in appendix 3.

## 5.2.3 Delivering Service Transformation for Better Mental Health

Mental health services in Manchester are currently seeking to deliver a variety of strategies, initiatives and developments. These include the local 10 year commissioning strategy for mental health, the Joint Needs Strategic Assessment, implementation of national guidance such as National Service Frameworks and the recommendations of the recent report by John Boyington CBE.

Mr Boyington's report, published in July 2008, produced 18 recommendations for improvements to the way mental health services are commissioned and provided. We have placed these into the following themes: resource management, relationship management, communication, appointments and engagement. Together with our co-commissioners Manchester City Council and main provider organisation Manchester Mental Health and Social Care Trust, we have made a commitment to implementing each of these recommendations to ensure the necessary improvements are made.

In developing this work we have recognised the need to develop a robust strategic commissioning framework in mental health. This will include a comprehensive work programme for commissioning with multiple workstreams, including a commissioning prospectus for mental health and reviews of governance and accountability frameworks, contract systems and performance frameworks.

We are also committed to maintaining the current levels of investment in mental health in Manchester, while the Improving Health in Manchester programme has secured significant additional investment to tackle and reduce the mental health inequalities in the city.

## 5.2.4 Practice Based Commissioning

We have three operational Practice Based Commissioning (PBC) hubs in the north, centre and south of the city, all of which will have a vital role in delivering this plan. The hubs already have a reputation of success in enabling locally



sensitive, clinically led commissioning and this is reported quarterly to our Board.

We have recognised the potential of increasing the current scope of PBC to achieve the outcomes and priorities set out in this plan. We believe this can be achieved by creating stronger PBC hub capabilities in commissioning, particularly in relation to an extended role in the commissioning of primary and community services. An 'escalator' model is being developed which considers key competencies and capabilities.

This will have a significant impact on an emerging accountability framework for PBC, which will form an important part of our assurance mechanism. This is currently in development and will be presented to our Board in November 2008.

As PBC develops there will be important opportunities to consider the most appropriate organisation form to undertake the new challenges. South Manchester PBC hub has already presented a proposal to the Board outlining its wish to establish a social enterprise model in order to provide an integrated approach to commissioning services in South Manchester. The Board has supported the South Hub to explore this business model and produce a business case, which will be presented to our Board in December 2008. The concept of integrated care organisations is also being more broadly considered by the three PBC hubs as a vehicle for delivering some of the strategic initiatives described in this plan.

## 5.2.5 Further Developing and Embedding Engagement in Commissioning

Patient, public and stakeholder engagement will be key to delivering this plan, therefore we are now planning:

- a conference for stakeholders in November 2008 to share progress on World Class Commissioning including this plan, feedback from Talking Health and progress in implementing the proposals generated from the Improving Health in Manchester programme;
- an annual survey of myNHSmanchester members to complement and inform the Joint Strategic Needs Assessment;
- mechanisms to ensure that patient experience data forms key part of the contract monitoring process with providers;

- improved coding of public feedback to facilitate accurate identification of themes to inform commissioning decisions;
- the analysis and publication of the full final results of the Talking Health Discovery Survey, together with insights from other aspects of Talking Health to further inform the implementation of this plan. Patient and public input is being planned into the programmes of work within each of the strategic initiatives; and
- further clinical engagement. Effective partnership between managers and clinicians is crucial to the delivery of the strategic initiatives, as described at the start of this document in the foreword by Dr Liam McGrogan. The continued development of practice based commissioning is central to this agenda within the three localities, but increasingly the role of the Professional Executive Committee is required to influence clinical quality at both an NHS Manchester level and as part of the Greater Manchester health economy in large scale system reform, such as the implementation of the Healthy Futures and Making it Better reconfigurations.

## 5.2.6 Equality and Diversity

The NHS Manchester Single Equality Scheme (SES) will be a key enabler to the effective delivery of the plan, with agreed priorities for each equality target grouping. Disaggregated population data with regards to equality target groupings is currently patchy. The approved SES identifies this as our main area for improvement, with agreed actions for both provider and commissioning functions that will be monitored through the Equality and Diversity subcommittee.

A major plank of this improvement will be achieved by our significant new investment (around £400K) in facilitating and increasing the collection of good quality ethnicity data in primary care - through the provision of a new joint outreach service with voluntary and community sector organisations and practice based commissioners.

The service will assist patients and individuals to access primary and community services, overcoming language and cultural barriers; as well as building stronger relationships between the voluntary and community sector groups and primary care contractors. The service will be complementary in supporting General Practice to achieve the targets as part of the new Directed Enhanced Service for improving ethnicity data collection for all registered patients.





Managing the performance of our provider arm's services in relation to equality monitoring is also a priority of the SES. This is in addition to embedding equality and diversity throughout the commissioning cycle as highlighted earlier in this plan.

As described in strategic initiatives 1 and 2, the aim of the health trainers and health living networks will be to focus their intervention to reach those communities who do not currently access mainstream services. We have successfully recruited health trainers with the ability to speak a total of ten different languages, which will be an asset in supporting our diverse population

### Equality Impact Assessments

Building on our current successes of incorporating Equality Impact Assessments (EIAs) into our commissioning business processes, each delivery team will continue to work within the agreed model for conducting EIAs. This will include mandatory refresher training in EIA where appropriate. Meanwhile each individual staff member will be required to outline how they will incorporate equality and diversity as part of their contribution statement with their line manager.

NHS Manchester has a strong commitment to engagement and involvement of patients and the public. Recognising the transient nature of the Manchester population, we will further strengthen our approaches to involve existing and new communities, working in partnership with the voluntary sector. We value the views, comments and opinions of the equality and diversity reference group that has supported the development of this plan and will continue to meet throughout its implementation on a regular basis.

Involvement in National Programmes - Race for Health and Delivering Race Equality in Mental Health

As the lead organisation in the national Race for Health programme, the Board of NHS Manchester has committed to a series of key performance indicators (KPIs) that will be another key enabler in improving health outcomes for black and minority ethnic communities, with specific focus on diabetes, mental health, coronary heart disease and stroke. The KPIs for Race for Health are prioritised within the SES and aligned to the priorities of this plan. We have achieved our target of recruiting eight Community Development Workers specifically focusing on the needs of new and emerging black and minority ethnic communities in the city.

## 5.3 The Operational Plan

The delivery of the commissioning strategic plan will be our core business in the current financial year and beyond. The detail will first be described in the operational plan for 2009-10. The current operational plan was developed in March 2008 and will be refreshed between November 2008 and March 2009 to reflect the key deliverables described here.

The Organisational Development Plan is the second key strand in enabling us to deliver the commissioning strategic plan and for NHS Manchester to become a world class commissioning organisation.

The successful delivery of the goals and initiatives within this plan will be the objective of our next operational plan. This will include detailed delivery arrangements for each strategic initiative and will be prepared in four developmental stages, as follows:

**Stage 1 – evaluation and assimilation.** During this stage, our officers will review existing information and intelligence about implementation. This will include:

- reviewing the success of the current operational plan;
- seeking opinion from patient, service user and carer groups (including by review of documentation) to identify strengths and weaknesses of current operational plan execution;
- seeking opinion from staff responsible for execution of the operational plan, identifying good practice proposals;
- reviewing experience of other primary care trusts, especially those in London whose experience of operational plans is one year ahead of the rest of England; and
- reviewing advice and guidance from the Department of Health, NHS North West and relevant academic and advisory bodies.

**Stage 2 – drafting.** During this stage, we will prepare a first draft of the operational plan

**Stage 3 – new, challenge and refinement.** During this stage, we will seek comment, opinion and challenge from stakeholders on the first draft, with a view to amending and refining it to reflect feedback. Comments will be sought from key stakeholders including:

- patients, service users and carers;

- provider staff across all sectors;
- commissioning staff within NHS Manchester; and
- partners including Manchester City Council.

**Stage 4 – final drafting and approval.** During this stage, we will prepare a final draft of the operational plan for submission to the Board and onward submission to NHS North West.

## 5.4 The Organisational Development Plan

The delivery of this plan will require NHS Manchester to act differently with its partners, in its choice of partners, in how it communicates and engages with the people of Manchester and in how it operates internally. The outcomes created by focused and effective commissioning and service excellence through our commissioning functions will be as a result of well informed, well planned and disciplined execution, with organisational development at the centre of this change.

Our three organisational development priorities will channel effort into the areas which together will support delivery of this plan. Our intention is that both staff and external partners, where applicable, will be able to understand and relate to the three priorities, which are summarised below.

**Priority 1: Align organisation and activities with our commissioning strategic objectives, and build a distinctive NHS Manchester culture that puts engagement at the heart of how we work**

Examples:

- A communications programme to ensure all commissioning organisation staff understand what the commissioning strategic plan and organisational development priorities mean for them
- A culture change programme branded 'Good Thinking' about aligning behaviours across the commissioning organisation and with our practice based commissioning colleagues
- Further developing the ability of our Board to provide world class commissioning leadership

**Priority 2: Re-shape structures and business processes to support our commissioning organisation**

Examples:

- Strengthening and streamlining our commissioning business process
- Defining our project and programme management approach

**Priority 3: Build our people's commitment, skills and capabilities to deliver World Class Commissioning and our Commissioning Strategic Plan**

Examples:

- Complete the implementation of developments already underway or undertake further work on capability and capacity of the workforce in the areas of evaluation, quality management, change and programme management, social marketing, disciplines such as health economics and predictive modelling, and strong procurement and negotiation skills. Skills gaps will be met through building them in-house, sharing the skills of other organisations, or procuring them.
- Conduct a specific survey of commissioning staff which acts as a skills audit and a cultural audit. This will inform the development of a workforce development plan, and Training and Development planning.



# 6. Board Approval

This report was approved at the 1<sup>st</sup> October Board Meeting of the Manchester Primary Care Trust Board.  
The Board has been involved in the development process and agreed at the meeting to support this plan.



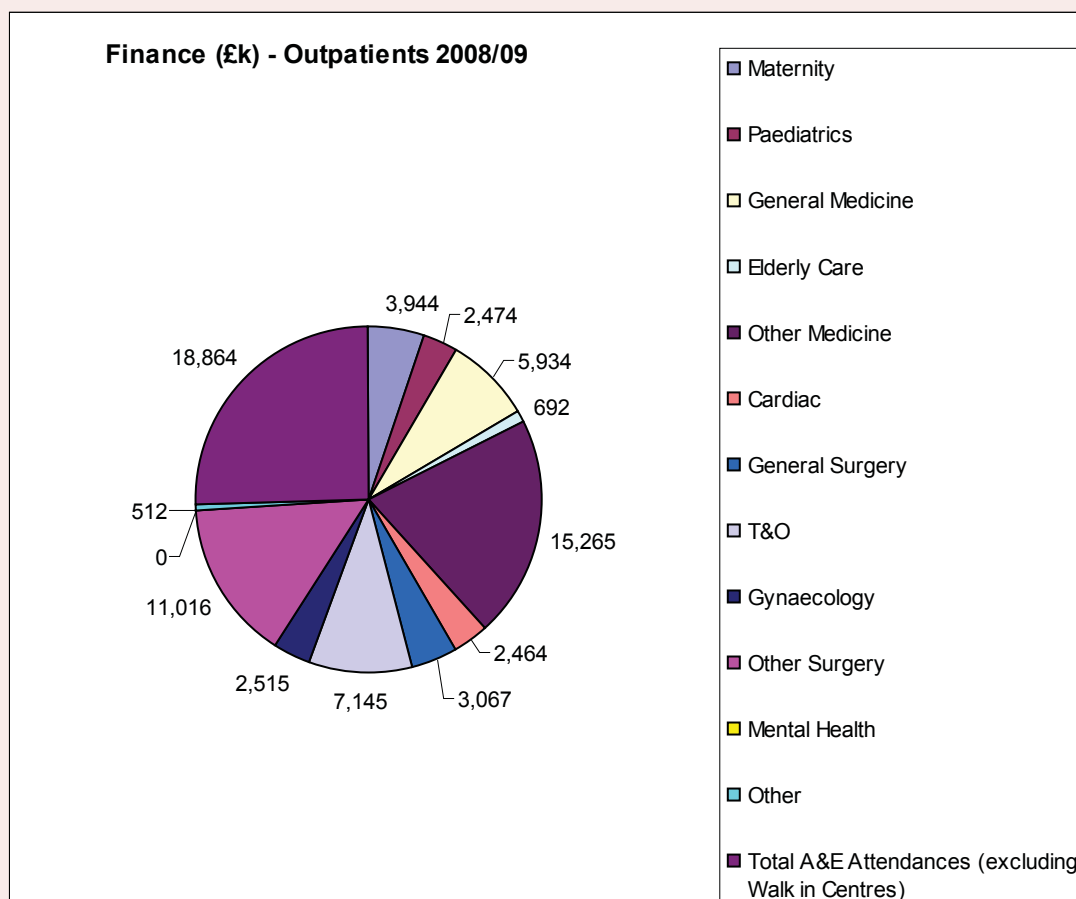
**Laura Roberts**  
Chief Executive



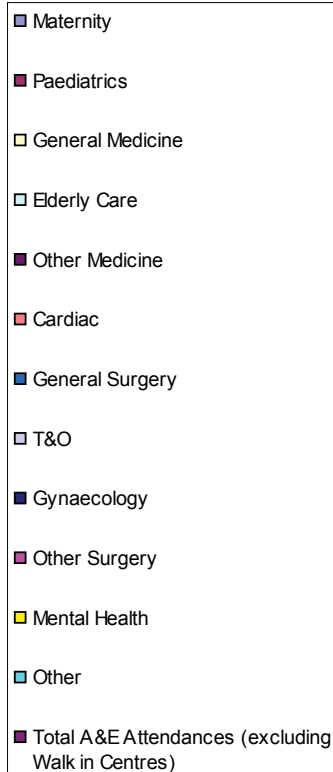
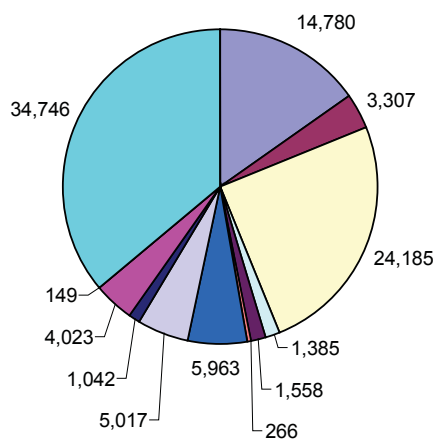
**Evelyn Asante-Mensah OBE**  
Chair

# Appendix 1

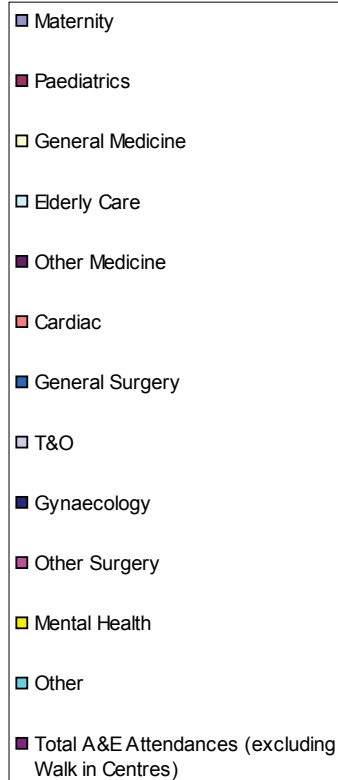
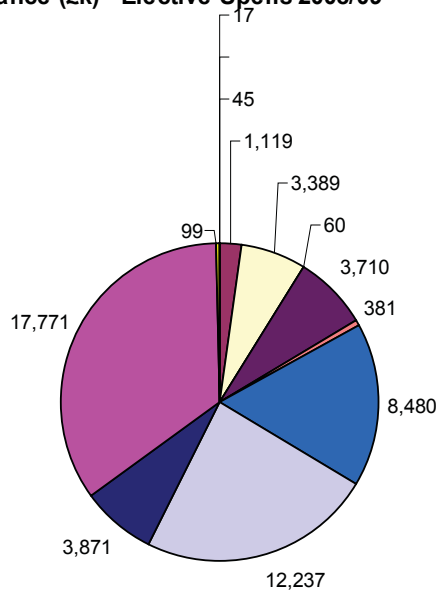
The budgeted spend for 2008/09 split by outpatient, emergency and elective spells:



**Finance (£k) - Emergency Spells 2008/09**

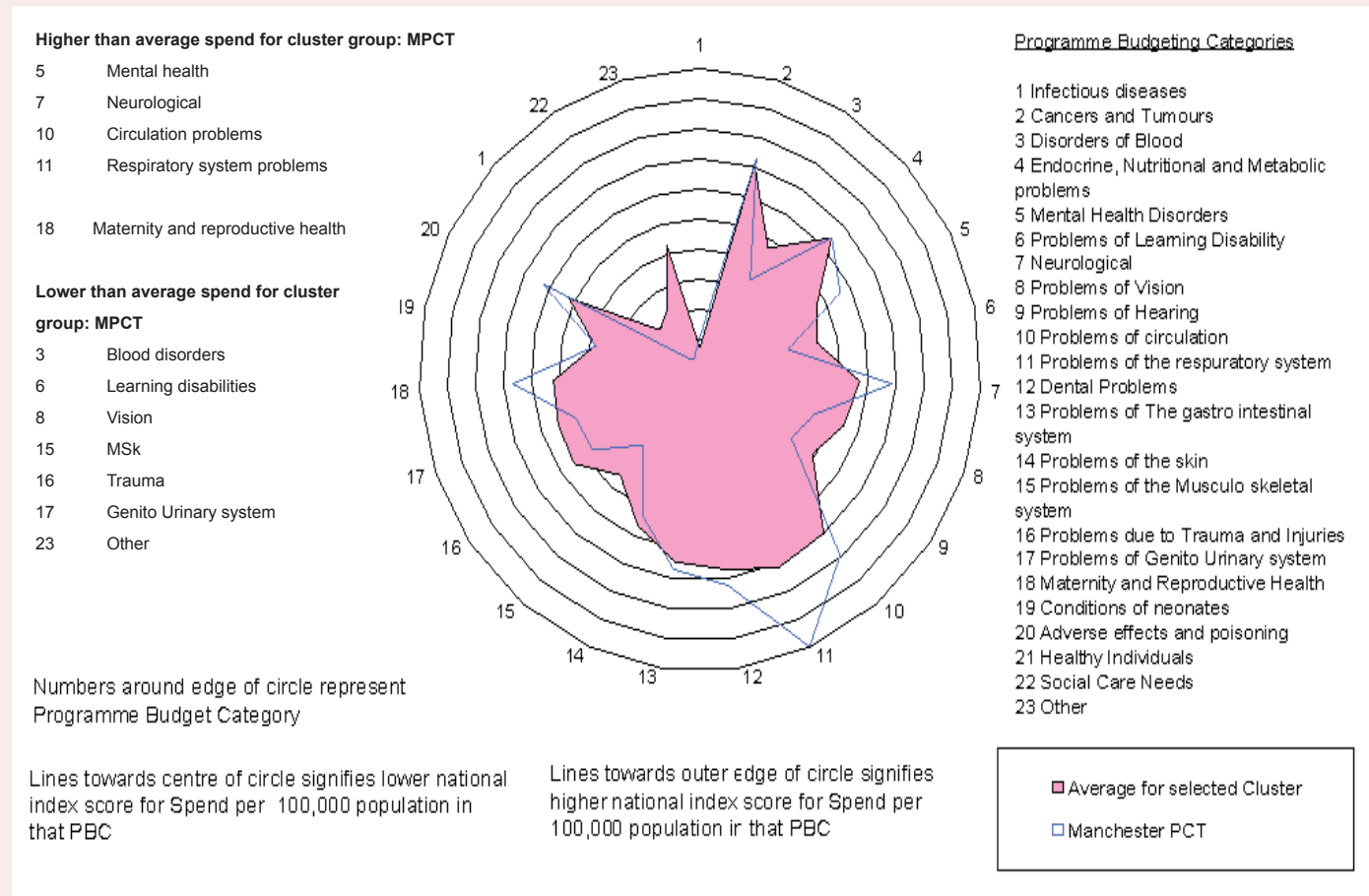


**Finance (£k) - Elective Spells 2008/09**



# Appendix 2

Analysis of the latest programme budgeting data available (2006/07) illustrates the following for NHS Manchester:





NHS Manchester						
Population (as per AI-locations)					608,340	
Programme Budgeting Category		Net expenditure 2006/07 (£'000s)	Change in expenditure (by unified population) from 2005/06	Expenditure as % of cluster average	Variance from cluster resource allocation (£'000s)*	Performance comments
1	Infectious Diseases	£16,196	11%	158.5%	£6,010	Expenditure is above expected given mortality from pneumonia.
2	Cancers and Tumours	£51,973	7%	108.5%	£2,805	Expenditure is above expected given mortality from all cancers.
3	Disorders of Blood	£6,894	-61%	78.1%	-£2,319	NA
4	Endocrine, Nutritional and Metabolic	£22,862	-3%	105.7%	£627	Expenditure is above expected given the prevalence of diabetes.
5	Mental Health Disorders	£120,123	4%	124.6%	£22,093	Given prevalence of psychoses, expenditure is close to expected.
6	Problems of Learning Disability	£21,924	11%	75.4%	-£8,476	Given prevalence of learning disabilities, expenditure is above expected.
7	Neurological	£39,516	63%	128.1%	£8,225	Given prevalence of epilepsy, expenditure is above expected.
8	Problems of Vision	£13,058	-9%	85.5%	-£2,820	NA
9	Problems of Hearing	£3,282	-20%	85.5%	-£706	NA
10	Problems of Circulation	£80,520	3%	119.5%	£11,824	Expenditure is above expected given mortality from all circulatory disease. Given the prevalence of CHD, expenditure is above expected.
11	Problems of the Respiratory System	£57,007	21%	147.8%	£18,325	Expenditure is above expected given mortality from bronchitis, emphysema and COPD. Given prevalence of COPD, expenditure is above expected.
12	Dental Problems	£29,910	74%	110.4%	£2,391	NA
13	Problems of Gastro Intestinal System	£46,371	3%	110.2%	£3,250	Expenditure is close to, but above, expected given mortality from chronic liver disease including cirrhosis.
14	Problems of the Skin	£15,827	13%	98.4%	-£771	NA
15	Problems of Musculo Skeletal System	£26,722	-35%	76.0%	-£10,038	NA
16	Problems due to Trauma and Injuries	£27,823	-40%	90.2%	-£4,143	Expenditure is below expected given mortality from accidents.

# Appendix 3

## Stakeholder Engagement

This table gives an overview of the process of engagement followed in developing this plan.

Date	Internal	External	Purpose/content
July	Project team meeting		
	Executive Management Team		Discussion of Outcomes
		Adults Health and Wellbeing Board	Discussion of outcomes and objectives in context of national and regional policy
		Practice based commissioning hubs	Discussion of outcomes
	All staff		Staff briefings
	Joint Consultative and Negotiating Committee		Update and feedback
	Project team meeting		
	Executive Management Team		Discussion of outcomes and goals prior to Senior Leadership Team session
		Health and Wellbeing Overview and Scrutiny Committee	Discussion of outcomes and objectives in context of national and regional policy
	Senior Leadership Team		Update and development of next steps for CSP and OD Plan
		North Manchester Health Summit	Share vision and invite input
August - September		Practice based commissioning hubs	Engage in strategic initiatives and delivery plans
		Members of Parliament	Briefings to engage in vision and invite input
		myNHSmanchester members	Briefing and survey to test goals and priorities
		Communities of interest networks	Briefing and survey to test goals and priorities
August		Presentation to the Local Involvement Network	Briefing on goals and priorities
		All key external stakeholders	Letter from CEO/Chair outlining progress and purpose of CSP, inviting input



Date	Internal	External	Purpose/content
		360 participants	Letter from CEO/Chair giving advance notice of invite to participate in 360 process
		Equality and Diversity reference panel	Begin Equality Impact Assessment process
		Executive Member for Health and Social Care	Briefing to engage in vision, test goals and priorities
	Board		Key development stage and discussion
September	All staff		Second round of staff briefings
	Professional Executive Committee		Update and discussion on strategic initiatives
	Joint Consultative and Negotiating Committee		Update and feedback
	Board		Sign off 80% complete CSP prior to submission
		Public Service Board	Update and engage in vision, test goals and priorities
		Adults Health and Wellbeing Board	Update and engage in vision, test goals and priorities
October		Equality and Diversity reference panel	Continue Equality Impact Assessment
	Joint Consultative and Negotiating Committee		Update and feedback
	Board		
		Health and Wellbeing Overview and Scrutiny Committee	Present CSP, engage in vision and next steps
November	All staff		Third round of staff briefings
	Joint Consultative and Negotiating Committee		Update and feedback
		World Class Commissioning Panel	
		NHS Manchester Conference for external stakeholders	Launch CSP and engage in operational plan/benefits realisation

# Appendix 4

## Strategic Initiatives – full descriptions

### Strategic Initiatives 1 and 2:

#### Help people live longer and reduce the gap in health between different communities

The major challenges we face in improving health and reducing health inequalities have already been described. We have based achieving goals 1 and 2 (Life Expectancy and Health Inequalities) around the six high impact changes for the NHS. (DH tackling health inequalities 2007).

- Know your age gaps in life expectancy and infant mortality and develop a health inequalities strategy and programme of sufficient scale to make a strong impact on the gap
- Make smoking history – reduce smoking prevalence and target cessation services and campaigns in deprived areas and groups
- Target prevention of cardiovascular diseases using prevalence models to identify areas of unmet need alongside a case finding strategy
- Improve detection of cancer in local communities
- Ensure the quantity of primary care in disadvantaged areas is sufficient to address need and is of high quality. Focus Health Trainers and Life Check programmes on tackling health inequalities
- Empower disadvantaged communities to aspire to good health

As a result we have 6 initiatives with programmes of work to achieve goals 1 and 2.

1. To increase life expectancy by impacting upon inequalities in infant mortality in line with best practice guidelines of reducing smoking in pregnancy and increasing breastfeeding.

This initiative contains a programme of work with 3 elements:

- Breastfeeding Peer Support Service across Manchester

- this service would offer peer support to every breastfeeding mother in Manchester on an opt-out basis for as long as the woman continued to breastfeed.

- Infant Feeding Facilitators – these facilitators would provide training and support to PCT Children's Services staff in order that the PCT achieved UNICEF Baby Friendly Initiative accreditation and would audit for continual improvement.
- Smoking Cessation/ Tobacco Control – this additional investment would include targeting pregnant smokers and their families to reduce smoking in pregnancy and in the homes of young children.

2. To establish a "Tobacco Free Communities" programme, targeting those wards with the poorest health and highest rates of smoking, that will both increase the availability of stop smoking services and run local campaigns aimed at creating changes in social attitudes in this area.

The programme is based on using a community development approach to engage local partners and "champions" to devolve a tobacco free message and promote available cessation services.

Social marketing techniques and campaign approaches and materials will target groups including manual groups, pregnant smokers, minority ethnic groups and young people. The already established Manchester Smoke Free Homes Scheme and Nicotine Replacement Voucher Scheme will also be intensified.

3. Cardiovascular Disease (CVD) risk assessment and management.

This initiative contains a programme of work to include:

- Implement predictive CVD risk registers by means of a contract with General Practice
- Medical management of individuals identified as high risk within General Practice
- Commission a community based vascular prevention programme to support very high risk individuals in lifestyle change;



- Contract with community pharmacists, optometrists, dentists and other providers for lifestyle advice
  - Undertake NICE recommended audit of cardiac rehabilitation provision in relation to guideline CG48
  - Identify gaps in cardiac rehabilitation service delivery and develop service to meet need
  - Fund the delivery of “Heartstart” and “ORCS” education programmes in KS3 and KS4 (secondary schools)
  - Commission community pharmacists to support the delivery of the “Asking about Medicines as We Grow” education resource in KS1 to KS4
4. Improving the prevention and early diagnosis of cancer
- A wide range of initiatives that:
- Raise awareness of cancer symptoms
  - Promote early presentation for cancer symptoms
  - Ensure quality of and Increase uptake of screening programmes
5. Health Trainers Initiative

The Manchester Community Health Trainer Initiative builds upon the existing successful Health Trainer scheme. This initiative aims to expand the service to work with general practices to support those patients identified by GPs and Practice Nurses as being at risk of developing lifestyle related illness.

The role of Health Trainers is to support individuals in lifestyle change through using motivational techniques to achieve health related changes of behaviour. The focus of the intervention is particularly on food and nutrition, physical activity, smoking, alcohol consumption, sleep loss and mild mental health issues. Health Trainers are also trained to have a detailed awareness of local services/facilities in order to sign post and support people to access them. For example such services include leisure facilities and a range of support groups

#### 6. Manchester Healthy Living Network

The Manchester Healthy Living Network aims to support the achievement of goal 1; to help increase the average life expectancy of Manchester residents to 80 years by 2015 by the following:

1. Promote aspiration wellbeing and happiness in local communities – delivering sustained improvement to

the health of local people through behavioural change, community empowerment and the building of social capital.

2. Supporting vulnerable residents – engaging, supporting and involving local people and communities in health and wellbeing activity.
3. Partnership Working – support of existing and emerging health related partnerships and strategies including Valuing Older People, Food Futures Partnership, Alcohol Strategy, and the Manchester Crime and Disorder Partnership
4. Localised/personalised preventative services in partnership with communities and other organisations. Establishment of community health forums and the development and hosting of a wide range of posts with a focus on physical activity, food and nutrition, alcohol misuse and emotional wellbeing.
5. Promotion of Community Cohesion – Support of the PCTs race for Health programme which focuses on the health inequalities experienced by BME communities including diabetes, coronary heart disease and stroke and mental health.

### How it supports our goals

Infant Mortality supports goals 1, 2, and 5

<ul style="list-style-type: none"> <li>Tobacco Control</li> <li>Cardiovascular Disease</li> <li>Cancer</li> <li>Health Trainers</li> <li>Healthy Living Network</li> </ul>	}	supports goals 1 and 2
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Cancer also supports strategic goal 9, access to planned care

### Impact on health inequalities and outcomes

#### Infant Mortality

Year on year increase for breastfeeding at 6-8 weeks in line with Vital Signs requirements (Currently 21%); 35.4% 1008/9: 37.9% 2009/10: 40.4% 2010/11

#### Tobacco Control

To cut smoking prevalence in the general population to 15% by 2015 and to 19% amongst routine and manual workers, but such a reduction will be challenging in those areas of highest need when starting with a baseline of 46% in 2006.

## Cardiovascular Disease

CVD is the greatest cause of inequality in life expectancy between Manchester and the rest of the UK. Pilot work in General Practice suggests that there will be in excess of 8500 adults aged between 40 and 74 years, in Manchester, having a greater than 20% 10 year risk of CVD and requiring further intervention. It is planned that a programme of systematic assessment will review eligible adults; identifying and treating those at risk over a 3 year period. In addition, it is planned that 1350 adults and their families, per year will be referred to and supported by the MyAction programme.

## Cancer

Research has shown that many people are unaware of the symptoms of cancer and may therefore delay presenting to their doctor, thus putting at risk their chances of survival. It has been estimated that approximately 500 lives could be saved in Greater Manchester each year if people went to their GP early.

Research has also shown that those most likely to present late are people in their 50s and 60s living in deprived areas and from lower socio-economic groups.

Social marketing and community development approaches can be particularly effective in raising awareness and the PCT will commission both. This will ensure people understand what the signs and symptoms of the priority cancers are and that they are supported and encouraged to go to their doctor earlier, especially in the most deprived parts of the city.

In addition the screening programmes for bowel cancer and breast cancer will be extended in line with the recommendations of the National Cancer Reform Strategy.

According to national guidance, a HPV vaccination programme has been introduced, beginning in Sept 2008 in School Year 8 and incorporating a catch-up programme to ensure vaccination of all girls between the ages of 13 and 18 by 2010/11.

These initiatives combined with the expansion of the Healthy Living Network, increases in the Health Trainer Workforce and introduction of the smoke free wards programme will enable Manchester to achieve the 2011 target. Current projections highlight that this target remains challenging.

The social marketing and community development approaches in conjunction with the other initiatives would be expected to impact on outcomes in 2009/10 and 2010/11 respectively. The upper age limit for bowel cancer screening

will increase from 69 years to 75 years in 2010. The breast screening programme will be extended to invite women aged 47-50 and 70-74 in Greater Manchester on a rolling programme, commencing in Q4 2008/09.

## Health Trainers

The Health Trainers initiative offers a number of potential health gains/financial implications for the population of Manchester and Manchester health services that can result from improved lifestyles.

- Those stopping smoking have a 13% reduced risk of death in the first 5 years after quitting (and no extra risk 20 years after stopping)
- It is estimated that each of the 79% of the city's inactive population costs the city £370/year.
- 26% of the total prescribing costs can be attributable to overweight and obesity.
- A drop of one Body Mass Index unit has been shown to reduce incidence of type 2 diabetes by 13%.

The above assumes the following:

- 15 new patients are seen per week by each Health Trainer (April 2009)
- Each Health Trainer works for 45 weeks per annum (April 2009)
- The cost saving for each person becoming active is £370 per annum. This is a prudent estimate as it excludes savings generated from other areas such as patients that stop smoking (2010)

## Healthy Living Network (HLN)

The outreach programme of the Manchester HLN will:

- Engage 30,000 local residents per annum (2009/10)
- Establish 13 Local Health Forums (2009)
- Support Health Trainer and Life Check programmes (80% of clients seen from socially deprived communities: Source DOH 2008) (2008).

Establish a community cancer prevention programme in line with the cancer Strategy to support an increase in cancer screening in worst performing wards (2009).

## Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost: £5,909,000





Savings identified: £3,003,000  
Net cost: £2,906,000

### Infant Mortality

Investment sought from Improving Health in Manchester programme

### Tobacco Control

The local target to increase the number of people quitting smoking using NHS Stop Smoking Services from 4,080 in 2007/08 to at least 4,859 in 2010/11 measured at 4-week follow-up. These targets will now be reviewed in 2009/10 to match the 1.4% increase in the general population (ONS, August 2008).

Based on an average of £2k cost per life gained, the proposed programme would only require another 50 smokers quitting every year to represent value for money.

### Cardiovascular Disease

Based on a study undertaken in Yorkshire it can be estimated that for a population the size of Manchester, savings in acute admissions costs could be in around £4.4million over 5 years for a moderate risk reduction and £7.1million for a risk reduction of 5-6%.

### Cancer

The proposed investments include a business case for investment in social marketing and the utilisation of external grants from the Department of Health.

### Health Trainers

#### *Impact on activity*

Of the estimated total number of new patients to be seen by the Health Trainers (c.10,800 per annum) it is estimated that 13% will need to become active, if net savings are to be recovered. Hence the tipping point for the business case is estimated to be 1,369 patients becoming active. Whilst it has been difficult to obtain suitable data to confirm the level of patients that become active it is believed that 13% is an achievable target such that it will be exceeded and savings can be generated from this business case.

### Healthy Living Network

- 50% increase in local communities engaging in HLN activities, based on local evaluation studies, would include up to 60% of participants previously not engaged with preventative services, approximately 18,000 individuals that can be helped to reduce their chances of developing

a Chronic Disease thereby reducing the commissioning costs to the PCT (2009/10)

- HLN will support the existing and expanded Health Trainer Programme as it is developed across 16 primary care practices (thereby supporting work to engage socially disadvantaged groups as evidenced in Health Inequalities: Progress and Next Steps, pg: 68.DOH 2008).

The HLN supported cancer prevention programme will increase the level of preventative cancer screening in the worst performing wards of Manchester leading to an increase of 40% in these wards. This will lead to a reduction in later stage referrals for cancer services leading to a reduced cost to the PCT through unnecessary hospitalisation (2009).

## Investment/ disinvestment requirements

### Infant Mortality

Investment sought from Improving Health in Manchester programme totalling £876K

### Tobacco Control

In 2008/09 £180,000 has been secured through Staying Health Focus Team Bids to fund 3 Community Based Project Workers (Band 6 plus on-costs) and campaign funding for the 4-6 targeted areas. Funding will need to be replicated into phase 2 and 3 in 2009/10 and 2010/11 after an extensive evaluation of the programme which would include an annual Equity Audit.

Investment in Nicotine Replacement Therapy will also be required into years 2 and 3. The investment required will be £20K.

### Cardiovascular Disease

The estimated total cost of providing all elements of the programme for the first full year is £2.8m.

The estimated total cost savings in terms of acute admissions, assuming a risk reduction of 4-6% is in the region of £1.4 million per annum

### Cancer

Many cancers are preventable and survival rates can be improved through early presentation and diagnosis. When death rates fall and survival rates improve as a result of the programme there will be an opportunity to review the investments in secondary and tertiary care. More effective screening programmes will lead to an increase in diagnosis of cancer at an earlier stage. It is anticipated that this will lead to an increase in secondary care activity (surgery, radiography

and chemotherapy), but of a less complex nature. Palliative care costs would also be anticipated to reduce.

However it is important to note that because of our ageing population incidence of cancer is expected to rise in England up to 2020 (National Cancer Reform Strategy)

### Health Trainers

The Manchester Community Health Trainers programme has been live since October 2006. Health Trainers are currently based with different services across Manchester. Eight GP Practices are already using the service to refer patients who need to adapt their lifestyle behaviour. Early evidence indicates that of the first 834 clients seen 484 set an agreed action plan, with 59% of this group completely achieving their lifestyle change goals with the support of a Health Trainer. Aims included eating healthier, becoming more physically active, reducing smoking and consuming less alcohol.

The Manchester Joint Strategic Needs Assessment considers the impact of changes in lifestyle and risk taking behaviours on health and social care services in Manchester. Accordingly, it estimates that between 34%-38% of adults in Manchester smoke and 22.5% of adults in Manchester consume alcohol to hazardous levels. Indeed alcohol is estimated to be responsible for £7.1 million in-patient costs in Manchester. Over 25% of adults in Manchester are obese, this being equivalent to 95,000 people. Fifty-one percent of Manchester adults reported that they undertook rigorous physical activity less than once a week. All of these behavioural lifestyle areas are integrated within the Health Trainer intervention.

### Healthy Living Network

Manchester's HLN will provide support to new and existing services to support a programme of increased investment in prevention and early intervention. In line with DOH High Impact Changes to support reductions in life expectancy the HLN will seek to empower disadvantaged communities to aspire to good health.

The rationale for this service is derived from the Manchester Joint Strategic Needs Assessment (JSNA) 2008 and supports the following clinical priorities as identified by the JSNA:

- **Diet and Nutrition** – estimates suggest that up to 25.8% of adults in Manchester are obese (95,000 people). Over 900 deaths in Manchester every year can be attributed to diet-related cancers and coronary

heart disease. Manchester HLN will provide targeted interventions for BME groups such as salt reduction and cook and taste sessions in partnership with the Nutrition service and will extend the provision of community food workers as part of a broader healthy lifestyle strategy.

- **Alcohol Misuse** – 22.5% of adults in Manchester consume alcohol at 'hazardous' levels and 8.8% do so at levels harmful to their health. Manchester HLN will target provision of brief interventions with identified groups who are less likely to access services as a consequence of deprivation and social exclusion
- **Physical Activity** – 57% of Manchester adults take moderate exercise. Manchester HLN will develop weight-management services that reflect needs of deprived sections of local communities offering alternative options for achieving weight loss and will provide additional individual support through the established and expanding Manchester Health Trainer Service.
- **Cancer Prevention** – future projections suggest that by 2015, the rate of new diagnosis of prostate cancer in Manchester is likely to have increased by 47% and that for breast cancer by 19%. Manchester HLN will increase prevention and public awareness programmes in the worst performing Manchester wards to help individuals identify early signs and symptoms of cancer and encourage early presentation to primary care.

## Stakeholder engagement in the formation of the initiative

### Infant Mortality

The initiatives have been subject to various strands of community consultation on the provision of services for pregnant women and infants, including at maternity units, children's centres and community settings.

### Tobacco Control

Manchester Smokefree Working Group coordinates the joint planning and delivery process across the Local Authority and PCT.

Consultation on Manchester Tobacco Control strategy will begin in January 2009

The Tobacco Free Communities programme is being consulted upon in the pilot area of Harpurhey via ward coordinators, statutory and voluntary sector, residential groups and organised public events.



## Cardiovascular Disease

The CVD programme initiative has resulted from the Improving Health in Manchester programme partnership work. The Primary Care Focus Group included representation from GMPTE, pharmacy, dentistry, PBC, Primary Care Commissioning, Public Health, PCT Finance Directorate, PCT Access and Inclusion, Voluntary Sector Agencies and Manchester City Council.

Local community events have been utilised to raise awareness of CVD risk assessment and management. This informal contact with Manchester residents has been used to gauge interest in the subject.

## Cancer

The pilot Healthy Communities Collaborative is a project to raise awareness of the signs and symptoms of breast bowel and lung cancer in three target wards in North Manchester. The evaluation of this community development approach will inform the wider roll out and the Steering Group has involved both health professional and members of the local community

The Don't Be A Chancer Campaign has demonstrated the effectiveness of the social marketing approach, testing out messages with the target population and using techniques such as segmentation.

In Q2 2008, questionnaires about access to and experience of breast screening were sent to 4,517 women in South Manchester. In the first 10 days, 549 responses were received. The results are currently being analysed and will inform the future implementation of this initiative.

## Health Trainers

Development of the expanded service has been based upon local and national evaluation, which has included a user satisfaction survey.

## Healthy Living Network

Members and users of the existing South Manchester Healthy Living Network and the North Manchester Healthy Living Network (ZEST) have been engaged in the development of the business case to develop a citywide HLN. Existing Health Forums have been consulted through the SMHLN Evaluation (2008-ongoing) and the ZEST Evaluation (2008).

## PCT capabilities required

### Infant Mortality

The breastfeeding peer support will be tendered out of the PCT.

Suitable additional PCT staff will need to be employed as Infant Feeding Facilitators.

### Tobacco Control

The recruitment of 3 Community Project Workers will help enhance activity and support sustainability within the chosen wards once the funding from the Staying Healthy Focus bids is devolved.

### Cardiovascular Disease

This is a large programme of work for the PCT which will require skilled programme management capacity.

### Cancer and Health Trainers

Better understanding of social marketing skills and concepts.

### Healthy Living Networks

Economic Analysis capability to evaluate economic/ financial impact of community based health promotion interventions



## Implementation Risks

Title of Risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Failure to recruit staff and volunteers for the Breastfeeding Peer Support Service	Medium	Service could not fully operate without sufficient numbers of recruits.	Use Children's centres and local agencies eg Black Health Agency to advertise
Infant Feeding Facilitators fail to fully engage healthcare staff in the breastfeeding agenda	Medium	Staff may not prioritise developing breastfeeding skills.	Staff will be involved in evaluation of training and in progress reports, encouraging recognition of value of quality breastfeeding service development.
Financial risks of increasing prescription numbers for Nicotine Replacement Therapy	Medium	Increased demand over and above the level currently anticipated by the service, leading to pressures on the prescribing budget.	The Stop Smoking Service is well used to managing cost pressures on their NRT budget, as these have risen every year.
Unable to hit LDP 4-week smoking quitters targets	Medium		With the increase in the general population the Manchester Stop Smoking Service will reconfigure 4-week quit targets in April 2009 in consultation with key stakeholders.
Lack of clinical engagement in CVD programme	High	The operational introduction of this programme of work will be dependent upon clinical engagement, particularly in General Practice and pharmacy.	PEC and PBC boards will have a crucial role in clinical engagement.
Financial pressures associated with CVD	High	There is a risk that spending on prescribing and diagnostic activity will increase before reduction in costs associated with reduced morbidity are realised.	Efficiency savings in other areas of prescribing may partly offset increased prescribing costs in relation to CVD prevention. Clear referral criteria for screening in pharmacy and other provider settings will ensure that activity is targeted to areas of greatest health impact
Commissioning and procurement processes for social marketing	Medium	PCT has limited experience of this to date. The PCT has been a partner in Don't Be A Cancer Chancer campaign but this was initially commissioned through the Christie.	The risks could be mitigated by learning from best practice in PCTs with similar health profiles and challenges (e.g. Liverpool)



Title of Risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Capacity to extend population based screening programmes	Medium	There is a risk that existing screening providers are unable to develop sufficient capacity to extend age range within the required time scale	Monitoring by PCT commissioning groups. Development of contingency plans.
Failure to recruit and train sufficient Health Trainers	L	HT initiatives rely upon recruiting local people that possess local knowledge of communities. Failure to recruit local people may result in lack of take up of initiative.	Over 300 people applied in last 2 Health Trainer recruitment days. Similar recruitment methods will be adopted.
Failure to attain expected behaviour change	M	Sign up to lifestyle action plans and achievement of lifestyle goals is unpredictable and dependent upon patient compliance.	Current monitoring data is encouraging with statistics suggesting that 59% of clients achieved their stated behaviour change goals.
Lack established evidence base for HLN activity	M	Although there is a range of qualitative data to support the requirement for a HLN there remains a lack of quantitative data to support HLN outcomes	An evaluative framework has been costed as part of the Manchester HLN Business Case. The Evaluative Framework will seek to capture health outcomes that can be linked to the provision of the Manchester HLN

## Strategic Initiative 3.

### Reduce the number of teenage conceptions

This initiative consists of three parts:

1. Clinical Outreach in Hotspot Wards - To target and deliver clinical outreach sessions in five of the hottest hotspot wards and on further education sites, at least 12 sessions per week.
2. Prevention Team - To establish a prevention team to work with young people identified as vulnerable to teenage parenthood, to address their risk factors and to facilitate their access to contraception and sexual health services.
3. Teenage Pregnancy Programme - to deliver improvements in the priority areas of: improving access to contraception and sexual health services; improving sex and relationships education; improving targeted prevention; and better support for pregnant teenagers and teenage parents.

#### How it supports goals

This initiative aims to support the achievement of strategic goal 3: To halve the expected gap in the conception rate by 2015

#### Impact on health inequalities and outcomes

Reducing the number of teenagers who become parents is central to wider ambitions to reduce health inequalities, social exclusion and child poverty. Improving access to and uptake of contraceptive services is a critical part of preventing teenage pregnancy and averting the health inequalities faced by teenage parents and their children in later life.

The Clinical Outreach service will be commissioned during Q3 2008/09 and we expect sessions to be introduced on a phased basis from Q4 onwards.

#### Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost:	£276,000
Savings identified:	£335,000
Net cost:	-£56,000

#### Clinical Outreach

The clinical outreach clinics will deliver up to 576 sessions per year and will see up to 5,760 clients. The service will see young women and young men at a ratio of 2:1. In Q4 2008/09, the clinics are expected to see 1,320 young people.

From Year 1 (2009/10) and beyond, the additional hotspot clinics will be fully operational, well publicised and well used and the expected number of clients per year will be 5,760.

The impact of this service on finance is three fold:

1. The increased costs of prescribing contraceptives (average cost of £100)
2. The increase in Chlamydia screening (R U Clear) and for other Sexually Transmitted Infections (average cost £5 (R U Clear))
3. Savings made in preventing teenage conceptions in termination services, maternity services, health visiting and other paediatric services (cost of a conception regardless of outcome £2,048).

#### Prevention Team

In Year 1 (2009/10) it is expected that 1,066 high risk young people will be part of the case load of the prevention team. In Year 2 (2010/11), the numbers of young people involved with the prevention team will increase to the intended 1,423 per year.

#### Investment/ disinvestment requirements

Funding to deliver the clinical outreach service has been obtained through Improving Health in Manchester.

The Teenage Pregnancy Programme is funded until the end of 2010/11 through the central government grant for teenage pregnancy; additional investment may be required after this date.

Investment will be required for the additional prescribing and screening, however long term disinvestment in secondary care (terminations, maternity services) is expected.

#### Stakeholder engagement

The Health Equity Audit (HEA) for Young People's Sexual Health services, produced following consultation with young people, recommended the introduction of clinical outreach services. Provider organisations have also been consulted through the Sexual Health Forum and are supportive of the initiative.

This initiative is also in line with the strategic approach outlined by the Teenage Pregnancy Partnership Board and shared with stakeholders at the National Support Team event held in January 2008.

#### PCT capabilities required

No additional capabilities are required.





## Implementation Risks

Title of Risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Outreach clinics will not be established to stated timescale	Medium	There will be a delay in establishing clinics resulting in lower activity in Y1	Commissioning process commenced to establish service as soon as possible
Outreach clinics will not deliver the stated number of client contacts	Medium	The number of client contacts have been calculated using the best available evidence but could be an over estimation	Ensure that the total number of potential sessions are delivered and that these are well promoted to young people
Funding not obtained for Prevention Team	High	Failure to secure funding will mean that this service and associated benefits will not be achieved	Continue to seek funding to establish service.
National grant for teenage pregnancy not renewed	High	End of the Local Implementation Grant at the end of 2010/11 will mean that the central coordination and LIG-funded commissions will be unfunded.	Contingency plans need to be developed to ensure core services can continue post 2010/11

## Strategic Initiative 4

### Reduce the number of alcohol-related hospital admissions

This programme will establish alcohol screening and brief intervention projects in the 3 Manchester A&E departments and within primary care. The programme will ensure that problem drinkers have access to early intervention at key points of access to healthcare and that heavy/dependent drinkers attending A&E will be provided with additional support to prevent re-admission.

#### How supports goals

This programme is designed to support goal 4 to reduce alcohol related admissions and will also contribute to goal 1 Life expectancy and goal 2 health Inequalities.

Alcohol related illness is now the number one cause of the gap in life expectancy between Manchester women and the England average.

#### Impact on health inequalities and outcomes

It is estimated that people from deprived communities are 45% more likely to die from alcohol related conditions. Initial modelling has demonstrated that full implementation of screening and Brief Interventions (BI) to eligible patients (currently estimated at 78,000 citywide) will result in substantial savings in mortality and bed days. There is a current programme of screening and BI in place at the MRI A&E department which will be developed with additional resources. The two other A&E departments will need to develop the project from scratch. A pilot programme of screening and BI will be established in primary care in 2008-9.

2008-9 Improve capacity at Manchester Royal Infirmary (MRI) A&E

2008 – Oct 2009 develop schemes at North Manchester General and Wythenshawe

2008-9 establish screening and a BI pilot in primary care  
2009- roll out primary care pilot and consider options for sustainability e.g. LES

**Impact on activity and finance** The financial impact for this initiative is anticipated to be:

Gross cost: £660,000  
Savings identified: £621,000  
Net cost: £39,000

A&E departments and GP practices will be given targets for initial screening and the delivery of brief interventions and referral with increases expected on an annual basis.

#### Investment/disinvestment requirements

The National Review of Effectiveness of Treatment for Alcohol problems (NTA 2007) estimates that the impact of BI reduces alcohol consumption by between 14-34% and A&E re-attendance by up to 50%. This will have a medium to long term impact on admissions. Immediate identification and interventions for alcohol related frequent admissions should have a short term impact resulting in the 1% reduction on trend that is required.

Reductions in admissions will be monitored and financial impact identified annually.

#### Stakeholder engagement

The initiatives described are based on the priorities of the Manchester Alcohol Strategy 2008-11. This citywide strategy is based on partnership between health, social care and community. The strategy was subject to extensive consultation with key partners and local communities of interest e.g. service users and carers; BME groups.

#### PCT capabilities required

The PCT has most of the capabilities required in terms of data analysis and project management skills. Two posts are being recruited to provide alcohol screening and brief intervention training and to support project monitoring and evaluation.

### Implementation Risks

Title of risk	Severity rating (LMH*)	Description of impact	Mitigating actions
A&E failure to integrate screening and BI	M	Failure to screen and deliver enough BIs to have sufficient impact on demand	Learn from evaluation of MRI pilot programme and link outcomes to continuation of funding.
Failure to recruit GPs to pilot screening and BI	M	As above	Offer GPs incentive payment and training and audit support

(L = Low, M = Medium, H = High)



## Strategic Initiative 5

### Reduce the number of children who are overweight

**Programme 1: Breastfeeding Peer Support Service** See See Goal 1 Life Expectancy (Infant Mortality))

**Programme 2: Family centred lifestyle support for the under 5s**

Training of Early Years workers to work with families of young children under 5 to support healthy lifestyles for the whole family.

**Programme 3: Community Food Workforce expansion**

This service will be an integral part of a coordinated programme for Improving Health In Manchester with defined links to other programmes addressing exercise/activity on referral, increased capacity in leisure services provision and an Early Years prevention programme around healthy weight which links with the Child Health Promotion Plan (CHPP).

### How supports goals

Tackle and reduce levels obesity in the Manchester population.

Address childhood obesity through promoting healthy lifestyles for families with young children.

### Impact on health inequalities and outcomes

To halt the growth in childhood obesity by 2010 and reduce the rate to 2006/07 levels by 2015. The 3 year LAA targets

for Year 6 school pupils are as follows:

2008/09- 25.66%

2009/10- 25.66%

2010/11- 22.98%

### Impact on Finance

Gross cost: £542,000

Savings identified: £0

Net cost: £542,000

### Investment/disinvestment requirements

The Department of Health National Support Team for Childhood Obesity recommended concentration on early years to address longer term childhood obesity goals.

Investment of £1.4 million will address the expected costs (£35 million over 7 years) of bariatric surgery for young people (teenagers). In addition there would be a reduction in other healthcare associated treatment costs for diabetes etc which will rise as obesity levels increase in the population.

### Stakeholder engagement

The Manchester Weight Management Steering Group includes representation from a range of key services working with families and young people.

### PCT capabilities required

Procurement and contract monitoring capacity.

## Implementation Risks

Title	Severity rating	Description of impact	Mitigating actions
Failure to secure sufficient funding to provide "industrial" level input across the city.	H	Levels of obesity and illness will continue to rise as will NHS costs.	Decision makers commit to prevention agenda and invest (not spend) NHS funding to address future health "timebomb".

## Strategic Initiative 6

### Make sure health services are safe

In order to reduce the risk of harm to our patients, we will invest in five approaches:

#### 1. Build Capability to Deal with Adverse Clinical Events

In order to build capability to support the reduction in avoidable harm, we will expand training in adverse incident management. This will include investigation skills, as well as training in managing the required changes based on learning and best available evidence. This Programme will also

- support the investigations of incidents in practice where capacity is lacking at present;
- enable the creation of local networks of practitioners working on patient safety in clinical settings.

#### 2. Implementing Best Practice

We are currently funding a 1 year pilot Trigger Tool Analysis Project within our local secondary care acute trusts. Trigger Tool Analysis (TTA) is an analytical approach which involves the proactive audit of records to identify trigger points for the development of adverse events. It provides an exciting opportunity to develop local baseline information on the incidence of adverse events in a limited number of settings. Central to this project is the involvement of clinicians in examining the safety of their own services and identifying improvements. The further roll-out of the TTA resource will enable patient safety in other acute units as well as the non-hospital sector to benefit from this approach, and identified lessons to be implemented across the city.

#### 3. Preventing Never Events

The Never Events list was pioneered by the US National Quality Forum in 2002; and as described, includes clinical events that should never happen. An initial set of 31 Never Events has been agreed as the PCT's Never Events List and is now being incorporated into acute trust contracts and quality review arrangements. The next important step is to assure our community that everything reasonable has been done to avoid these events ever occurring. This requires that providers proactively assess and recognise the likely risk of each Never Event occurring in their organisation; agree the mitigating actions and implement the relevant plans to ensure those mitigating factors are embedded into the organisation.

#### 4. Resourcing Patient Safety

None of the work above will be possible without a dedicated team within the PCT to support and coordinate it. At present the PCT is in a situation where it has limited intelligence regarding the degree of avoidable harm occurring within our organisations. The information base, reporting mechanisms and analysis processes need to be developed. This requires concurrent research support to be commissioned. Our Quality Profiles included in contracts with acute trusts will need to be developed for other than acute trusts and rolled out to other providers. We will also need capacity to support proactive reviews. Safety and proactive compliance will be built into all stages of the commissioning cycle; whether developing clinical pathways, proposal of a new initiative, developing service specifications, procuring of services or monitoring contracts.

#### 5. Expand and Re-Configure Community Infection Control Team (CICT)

This will involve the establishment of a CICT with a geographical focus (6 districts) to undertake infection control audits, provide infection control training and ensure infection control recommendations and guidance are implemented in all community healthcare settings. If implemented this would extend and expand infection control capability and competency in community settings in order to reduce infection rates.

### How the initiative supports our goals

The strategic initiative is designed to support:

Goal 6: To reduce the incidence of avoidable harm in the health care setting.

### Impact on health inequalities and outcomes

- Whilst hospital acquired infection can strike anyone, the impact will be most felt in the older population group; particularly those who are malnourished, or have a lower immunity; the most vulnerable in the community.
- The reduction in cases of C Difficile in line with national targets to be achieved by the end of March 2011.
- Increasingly consistent standard of clinical delivery
- Improvement in clinical standards in primary, secondary and community care
- Reduction in adverse events and iatrogenic harm
- Reduction in avoidable inpatient bed days



## Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost: £567,000

Savings identified: £743,000

Net cost: -£167,000

The CICT expansion will reduce inefficiencies in the current healthcare pathways and reduce costs in terms of the treatment of HCAs and acute bed days occupancy. For example, every case of C Difficile is estimated to cost £10,000. The team aim to reduce the numbers from the March 2008 figure of 551 for all acute trusts commissioned by the PCT with the potential financial impact of:

2008/09 Reduction to 434 cases

2009/10 Reduction to 343 cases

Beyond C Difficile, avoided harm will result in reduced need for extended hospitalisation, as well as reductions in treatments of and care for complications and injuries. This should also impact positively on compensation claims. However, hard data is relatively limited at this stage.

## Investment/disinvestment requirements

The initiative requires new investment in order to achieve

the goal and desired impacts. The anticipated savings in treatment rates however could support in large part the costs of the programme of work planned for this outcome.

## Stakeholder engagement

We are working closely with acute trust colleagues on the patient safety agenda for Manchester. We have agreed the Never Events list with them, and they are aware of our intentions to jointly develop a population avoidable harm measure.

The intended expansion of the CICT has been co-ordinated through the infection control health economy for the city within the Improving Health in Manchester programme process involving representation from across the NHS.

## PCT capabilities required

Capability and capacity building for enable and monitor patient safety in a robust and comprehensive manner will be required as part of the initiative as there is currently little of either in the system. Building Capability, Resourcing Patient Safety, and Expanding the CICT are aimed at expanding the capacity and capabilities of the PCT.

## Implementation Risks

Title of risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Reduction in available funds to build capability	H	Reducing the support to build capability, would place an unrealistic burden on existing staff and the ability to undertake good investigations..	Build extra training requirements into existing programmes for PCT staff
Low uptake of Trigger Tool Analysis by Clinicians	M	The tool is a method that clinicians can use to assess whether their practice is safe. If clinicians are disengaged, the ability to influence change would be severely hindered.	This is only one tool which can be used. Other methods of analysis should be identified so that clinicians could be given some choice.
Failure to take all reasonable steps to prevent Never Events and other serious events from (re-)occurring	H	Risk of such events remains unaltered, whereas it should be reduced through implementing available knowledge.	Revise contract requirements and ensure support through prioritising the implementation of safety interventions.
Unable to recruit to team due to skills shortages	H	Unable to deliver agenda	Agree funding quickly, advertise as widely as possible, remain flexible as to deployment of resources between initiatives

## Strategic Initiative 7

### Improve the quality and availability of primary care services

This initiative consists of 5 programmes designed to improve the quality of Primary Care Services. The programmes are:

#### 1. Procurement of GP practices

The procurement of four new GP contracts in wards where access to a GP is poor with a low number of doctors, high deprivation and disease burden - additional capacity for 26,000 patients. In addition the procurement of one GP Led health centre for registered and non-registered patients. This will provide additional capacity for approx 8,000 patients and a GP led walk-in facility.

#### 2. Procurement of NHS Dental Services

The procurement of three GDS contracts in the wards with no current NHS dental access, i.e. Baguley, Charlestown and West Didsbury. There are two other elements of additional NHS dental capacity: the procurement of additional sedation and domiciliary services for Manchester residents and the commissioning of out of hours and in-hours urgent access – seven days a week, 365 days per year

#### 3. Procurement of Extended GP Hours

Implementation of the national Directed Enhanced Scheme (DES) and development for a Locally Enhanced Scheme (LES) for practices who do not take up the DES. This will increase the number of appointments available to reduce waiting time to see a GP and allow more time within appointments for GPs to treat patients.

#### 4. Reducing Demand and Streamlining Patient Access

We are working in partnership with local pharmacies, to develop two key initiatives which will reduce unnecessary demand on GP surgeries. This will have the potential to free up a considerable amount of GP and staff time to be redirected to other services. It is estimated that around 60% of GP contacts are used for repeat prescribing and the schemes below will aim to reduce that by around 70% if applied to sensible and agreed local protocols.

With the increased use of local pharmacists for repeat prescriptions this would free up more GP time and release this cost to be reinvested in patient care. This could be implemented across the city with the aim of releasing 50,000 10 minute appointments per year; pharmacy intervention

would cost £2.00 per appointment so the saving per episode would be £11.001 Other costs for drugs would remain funded from the existing drugs budget and repeat dispensing is already part of the pharmacy contract so cost neutral.

A Pharmacy Minor Ailments Scheme would be encouraging patients to attend pharmacist led clinics to deal with a range of minor ailments directly without the need for prescription, also reducing the need for GP time.

#### 5. Developing the Manchester Standard

The Manchester Standard represents the quality mark being created for primary care services in Manchester. It will ultimately define the way we commission for quality from primary care, as it will be the vehicle to define expectations, support delivery, and holding to account. The Manchester Standard will thus enable achievements of outcomes such as improved access, improved and more equitable care of patients with long-term conditions, better prevention, as well as improved safety in primary care.

We have begun to set out a local framework for this based on standards contained within Standards for Better Health coupled with research and training: In five years time we aim to have easily accessible NHS services for people in Manchester with a strong quality mark that is consistently delivered across all four primary care services: that the PCT can demonstrate will deliver annual improvement against national and locally agreed standards.

### How does this initiative support our goals?

The strategic initiative is designed to support goal 7 by direct investment in additional capacity for NHS GP and Dental services and by raising quality standards across all of the primary care contractor services

### Impact on health inequalities and outcomes

The delivery of additional NHS services in wards where there is a lack or an absence of provision will immediately address inequalities in healthcare opportunity for these communities in Manchester. The new GP services will provide care for 34,000 people in some of the most deprived areas within the city and are anticipated to open in June 2009.

New dental contracts will be live around September 2009 and will provide additional NHS services for patients who do not have services at present in 3 deprived wards





Additional hours will allow all patients to have increased access to GP services and by the end of March 2009 this should be available in 50% of our practices. By the end of year 5 it is aimed for 70% of practices to be open with extended hours.

By the end of March 2010, the PCT aims to extend the repeat prescribing using pharmacy intervention in 100% of practices for appropriate patients.

The development of the Manchester Standard is a longer term challenge requiring culture change in practice and across 4 professions. With early work to determine the baseline for standard setting we are aiming by year 5 to show improvements in standards of care across all 4 contractor professions.

### Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost: £7,910,000

Savings identified: £550,000

Net cost: £7,360,000

The number of additional patient appointments has not been quantified although the GP services will provide care for 36,000 patients and Dental Services in 3 deprived ward areas.

The potential to release time and funding to support 50,000 GP appointments through the use of pharmacists' intervention would also have a financial impact worth an estimated £550,000.

The development of the Manchester Standard is a longer term culture change and not reflected in terms of additional activity gained at this stage. In future years as the impact of improved quality of care is realised it will be possible to assess how this has impacted on the access and availability of appointments for patients.

### Investment/disinvestment requirements

Additional investment has already been committed to the capital developments to procure new GP practices and additional hours. For the Dental Access initiatives, this is using PCT allocations for dental services; no new funding is therefore required over the next 5 years for programmes 1, 2 and 3 above.

For programmes 4 there will be the additional payment to pharmacists for the intervention of £2 per episode which for 50,000 appointments would be £100,000 per annum,

looking to save GP time in the order of £550,000 per annum (based on savings per appointment above).

For programmes 5 this is a requirement for additional funding as the PCT is not currently resourced to deliver this level of quality improvement.

### Stakeholder engagement

Stakeholder involvement has been undertaken for the procurement of the new GP practices and the investment in NHS dental services.

The planned stakeholder engagement for development of the Manchester Standard will principally concentrate on the Local Representative Committees and clinical providers plus a wide ranging public and patient engagement exercise to determine what their expectations of services are in primary care.

### PCT capabilities required

In developing the Manchester Standard there are capacity and capability requirements for the PCT as commissioners of services and also for the Local Representative Committees. Once the standards are in the implementation phase, wider development needs across all 4 contractor groups will be determined through audit and review and this has been costed into the initiatives described.

## Implementation Risks

Title of risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Delay in mobilisation caused by building contractors	M	Delay in access to new services for patients	<p>Ensure contracts contain appropriate clauses to recompense PCT in the event of delay to handover</p> <p>PCT officers to be members of project team to ensure early notice of problems and plans to resolve these</p>
Lack of provider interest in additional NHS contract	H	If there is a lack of interest in delivering NHS Dental services from the existing provider market, this would retain the current inequality in the most deprived wards	<p>PCT commissioners to test out the market interest prior to tender</p> <p>Develop a fallback plan to employ salaried dentists to be managed by the PCT directly</p>
Uptake of DES/LES options for extended hours does not hit 70% target by 2010	H	Lack of extended hours may result in further inequality being created in Manchester	<p>PCT to work very closely with LMC to gain support and develop the DES/LES schemes</p> <p>Personal visits to practices to explain how the schemes work and the potential benefits to patients.</p>
Lack of support from GP Practices to devolve responsibility for patient care to pharmacists	M	This would mean a reduction in the anticipated target of 100% participation and the full potential for reinvestment not realised across the City.	Working closely with the LMC, the LPC and local PBC Hubs to promote the scheme and describe where benefits realised would help to encourage a higher uptake from GPs
Ensuring target standards are realistic for achievement	H	If standards are set at too high levels and practices are seen to fail, this may discourage some practices continuing with the necessary culture change	PCT to recognise the need for smaller incremental steps to encourage all providers to improve, but allowing some flexibility for those who want to achieve more. The system will also need a strong element for reward and sanction.



## Strategic Initiative 8

### Make sure patients with a long term condition have a personalised care plan

The NHS next stage review outlines the use of personal care plans in care planning. By 2010, patients of all ages with a long term condition, including those with mental health problems, will agree 'goals' and services with their GP, carers or other healthcare professionals.

For those who already have a long term condition, evidence suggests that systems of proactive, managed care and supported self-care can translate into better quality of life for patients and carers, as well as more efficient use of resources. Nationally, approximately 80% of all consultations with GPs and 60% of hospital bed days are related to care for a long term condition or associated complications.

The roll out of care planning is central to providing greater choice for patients with long-term conditions, helping them choose the treatments, setting and providers that best suit their needs. Manchester will be at the forefront of this initiative by implementing the use of personal care plans for patients with COPD and diabetes in 2008/09, mental health 2009/10 and all long term conditions by 2010.

In addition, we intend to increase the opportunities for choice, control and patient centred care by commissioning exploratory work to investigate the impact of personalized budgets for people with long term conditions.

We anticipate that the introduction of individualised funding for our patients could lead to:

- greater personalisation of care;
- reduced capacity constraints in the NHS;
- better coordination of care for individuals with complex health and social problems in receipt of a number of services;
- greater transparency in the allocation of NHS funds;
- greater equity by allowing personalisation within the NHS rather than through the market place;
- better value for money through the development of personalised care that leads to health improvements without increasing costs;
- greater innovation and service development, with people enabled to explore different ways of meeting their health needs.

In addition to this we will improve the current Crisis Resolution Home Treatment (CRHT) service in order to provide adequate support to patients in their home and

manage their illness in the appropriate care pathway to reduce inpatient admissions and A&E attendances.

We have decided to invest in 4 initial programmes which will begin to roll out both personal care plans and funding to our community.

The Programmes to deliver this initiative will be designed to:

- affect large numbers of people within the population
- reduce attendance at A& E
- use resources more effectively

The four programmes are:

#### **Programme 1; Implementation of Personal Care Plans for Patients with Chronic Obstructive Pulmonary Disease**

This programme will target patients with COPD where information is available on a practice register. This will have the highest impact on urgent care targets such as emergency admissions and non elective excess bed days

#### **Programme 2; Implementation of Personal Care Plans for BME patients with Diabetes.**

BME groups with diabetes present a high priority for support as these communities also face a 50% increased risk of heart disease.

#### **Programme 3: Redesign Resolution Home Treatment (CRHT) service**

To ensure that the benefits of the service are realised by improving the current service ensuring that the correct model of care is followed by the distinct elements of the pathway. CRHT is a national target and we have been achieving quarterly targets set by DH to monitor this for the last two quarters in 2008. The focus during the next 3 years is to take this further to see a year on year reduction in inpatient admissions by 30% and to continue to meet the CRHT target annually.

#### **Programme 4: Personalised Budgets for Self Care Long term Conditions**

Pilot sites for this innovative approach will be requested in 2009.

We are also supporting the rollout of Information Prescriptions (IPs) in health and social care. IPs help to empower patients and carers and manage their care more effectively by signposting them to quality information. We intend that IP development will also be incorporated into the strategic initiative.

## How it supports goals

This Strategic Initiative supports goal 8: To ensure that all people with long term conditions are supported to be independent and in control of their condition maintained by personal care plans.

It also contributes to goals 1, 2, 4, 9 and 10.

## Impact on quality and outcomes

Long Term Conditions are the principal contributors to the inequalities in mortality between Manchester residents and the rest of England. It is therefore anticipated that the Initiative will support

- In the short term, improved Quality Outcomes Framework clinical indicators (particularly for CHD, Diabetes, and COPD), mapped against spend to highlight the most clinical and cost effective providers
- Reduced rates of complications
- Implementation of NSF and NICE standards including the NSF for COPD due in 2009
- Increasing numbers of independent contractors commissioned and delivering successfully against enhanced service specifications for High Risk Heart Attack and Stroke, Diabetes and COPD improving total population coverage and targeting at risk groups
- In the longer term, reduced prevalence and mortality.
- Improved patient satisfaction with care

The programme will be evaluated to highlight the reduction in unplanned readmission within 28 days and compare the performance on lengths of stay,

DNA rates, referral rates and first to follow up rates against acute trusts with a similar case mix.

## Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost	£1,900,000
Savings target:	£6,467,000
Net cost:	-£4,567,000

We anticipate that the programmes will shift greater numbers of people into tiers 1 and 2 of the model of care, with routine access to care increasingly into primary and community services.

We also anticipate more emphasis on case finding, case management and structured care should reduce the proportion of care received from urgent care services under emergency tariffs. However, there is likely to be an increase in expenditure on community tariffs such as district nursing at least in the medium term

Developing more targeted and localised services in primary and community care settings will address areas where there is a disparity between need and access, increasing uptake, particularly from harder to reach groups.

If the benefits of programme 3 are realised this initiative can result in a reduction in the need for inpatient mental health beds. In 2006 there were:

- 159 adult beds;
- 101 elderly beds;
- 16 PICU beds, and
- 10 mother and baby beds.

The aim is to have a reduction in the adult usage by 30% year on year, over the next 3 years.

In addition, the current bed occupancy rate can be up to 120%, this should be reduced to <90%



## Impact on activity and finance

KPI	Baseline 2008	Year 1	Year 2	Year 3	Year 4	Year 5
		2009	2010	2011	2012	2013
% Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality & Outcome	68.50%	70%	73%	76%	79%	82%
% reduction in Emergency Bed Days		10%	13%	16%	19%	22%
Proportion of people with long-term-conditions (LTCs) supported to be independent and in control of their condition	Complete baseline audit	15%	30%	55%	75%	100%
% of patients with a shared cared plan with adult social services	Complete baseline audit	20%	40%	60%	80%	100%
Number of patients with a personalised budget for continuing care	Prepare pilot	6	TBC	TBC	TBC	TBC

## Investment/disinvestment requirements

As there will be an increase in workload for general practice, the most appropriate pathway for investment will be via practice based commissioning. Investment will also be required for the “information prescription”, patient, professional training and education programmes, printing and development of the personal care plans.

Programme 3 may result in potential dis-investment in secondary care as a result of the reduction in beds.

## Stakeholder engagement

A strategy underpinning the Long Term Conditions Programme will be developed in partnership with the key stakeholders in Manchester. Each of the workstreams will include clinical leads, representation from patient groups and advocacy organisations and management support.

Broader involvement will be facilitated via consultation events e.g. on the re-design of the COPD pathway and via formal communications, etc.

User and carer involvement will be integrated in a number of ways:

- setting priorities for developing the model of care and reviewing proposals for new service developments.
- co-designing new care pathways and pilot projects e.g. COPD pathway
- taking part in discovery interviews to flesh out experiences of using services
- providing lay led health and support services such as

health trainers, health guides, expert patient programmes and disease specific courses

- contributing to the governance of LTC initiatives e.g. Breathe Easy patients are represented on the Pulmonary Rehabilitation steering group and Diabetes Steering Group.

## PCT capabilities required

The PCT has a team of specialist nurses that includes COPD and diabetes to support practitioners in the development of personal care plans.

They also have experience of developing and implementing patient education programmes for COPD & diabetes.

There is a PCT rolling programme for COPD and diabetes that could be adapted to address this agenda.

Practices will find that working with patients and personal care plans will be time consuming; the introduction of other health care professionals to support this agenda would be useful

An audit has been carried out to identify for which conditions care plans already exist and how they have been implemented.

Programme 3 may require training and education of the staff working with this model of care to ensure that staff are working to the fidelity of the model and the appropriate protocols and procedures are in place.

The PCT may also need to be more pro-active in understanding the key mental health performance indicators and managing service providers accordingly using a performance framework.

## Implementation Risks

Title of risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Emergency bed days (EBD) fail to decrease in line with predicted outcome	H	This is a high spend low outcome investment area	Quarterly EBD data is produced by provider each quarter and plotted against the outcome trajectory and total registered population. Discussion of EBD targets are factored into the performance management meetings with Trusts
Low uptake of Personal Care Plans by patients with Long Term Conditions	M	A target has been set within the Next Stage Review that by 2010 all patients with Long Term Conditions will have a PCP	The National Service Framework for COPD will raise awareness of COPD and the appropriate actions to be taken by patients  This is also true for diabetes, but the PCT must target BME communities in a culturally appropriate environment e.g. place of worship
Out of hospital services for COPD and diabetes are not developed	H	Emergency bed days will fail to decrease	The Central hub has commissioned a COPD pathway that will be adopted across the city  Practice Based Commissioning focus is LTC





## Strategic Initiative 9

### Improving access to planned care

Our vision for this initiative is that we will demonstrate continuous improvement in access; reducing waiting times for planned care and as a result improving health outcomes and patient experience.

We will deliver and sustain the maximum 18 week referral to treatment target; and also extend this to cover all areas of elective services including community services (removing 'hidden waits'); and, in mental health, access to psychological therapies. This will be achieved through re-designing existing care pathways as well as introducing new providers into the healthcare system, which will mean new capacity and choice.

We will improve access and further reduce waiting times by implementing seven major programmes:

Mobilising five new Clinical Assessment Treatment and Support Services (CATS) which are being commissioned collectively by the 10 PCTs in Greater Manchester from the independent sector. CATS will provide diagnostic and treatment services in general surgery, ear nose and throat, gynaecology, urology orthopaedics specialties – providing faster access to assessment, diagnostics and treatments.

Manchester will also introduce CATS services and primary care focussed pathways in three areas where we have experienced challenges in meeting waiting time targets: ophthalmology, dermatology and dental services. The proposed ophthalmology service model involves establishing CATS along with extending the ability of accredited primary care optometrists to deal with conditions such as glaucoma maintenance and low vision. The dermatology CATS model will deflect activity from secondary care and provide more accessible primary care services for patients. The future model of dental care will, as with ophthalmology, provide for the establishment of a dental CATS service along with enhanced primary care dental activity; the CATS providing services for orthodontics, oral surgery and restorative dentistry.

Working with existing providers in primary, community and acute services to review and redefine existing services and deliver efficiencies to ensure sufficient capacity and choice in the system.

Delivering new Primary care focussed pathways through Practice Based Commissioning (PBC); including introducing enhanced Primary care services, and enabling GPs to access

diagnostics directly to support patient management within primary care.

Identifying capacity gaps and encouraging innovation. Maximising opportunities for new and innovative service provision, including opportunities for new market entrants, including the third sector and independent sector as well as NHS providers.

Extending waiting time targets to cover all the community services commissioned by the PCT. We will ensure that initial assessments and treatments for all community services are delivered within 5 weeks; whilst also maintaining an absolute maximum of 18 weeks for all first definitive treatments.

We will deliver a maximum of 18 weeks waits for access to psychological therapies within the mental health system; which will not only deliver significant improvements on existing access, but also improve outcomes and likelihood of recovery for people with mental health problems.

### How it supports goals

This initiative is designed to support Goal No 9: Access to Planned Care by extending the range of treatments in the secondary, community and mental health setting that will be accessible within 18 weeks.

### Impact on health inequalities and outcomes

- Reduce waiting times
- Improve patient experience
- Move services closer to home
- Provide services to meet growing demand from patients
- Use new technologies to improve services; and, at the same time
- Reduce costs

### Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost:	£4,750,000
Savings identified:	£4,098,000
Net cost:	£652,000

#### 1. 5 IS CATS

Currently the PCT estimates that the 5 IS CATS will deflect a total of 15,000 referrals from secondary care, as follows:-

ENT – 2,713  
General surgery – 4,192  
MSK – 3,073

Urology – 1,996  
Gynaecology – 3,026

There will also be further CATS activity in the form of 2,166 referrals for time limited therapy and 685 procedures; 17,851 episodes in total per annum.

Most CATS activity is a substitution for existing activity being carried out within hospital outpatient departments; however, the improved service model and lower waits are likely to generate new demand from patients and referring clinicians.

## 2. 3 PCT CATS

### Ophthalmology

We estimate that the proposed CATS service will deal with around 6,000 referrals and 10,000 follow up episodes per year. The new service will be able to provide more primary care activity at reduced cost; whilst also recognising that demand is likely to increase as a result of a growing older population, new treatments, and quicker more convenient access to services.

### Dermatology

We project that the Dermatology CATS will deal with 6,000 referrals per annum, deflecting activity from secondary care and providing a more convenient and accessible service model for patients. We estimate that the new service model will also be able to generate some savings.

### Dental

We estimate that the establishment of a Dental CATS service will provide activity in the 3 areas, as follows:-

Oral surgery	projected 900 referrals per annum
Restorative dentistry	200
Orthodontics	1,000

This represents an estimated deflection of 40% of referrals to secondary care in the areas specified. The new service model will also be able to provide additional capacity in core dental primary care.

## 3. Redefining outpatient services with providers to develop CATS models

We will be working with existing providers, both in the Acute and Primary and Community sectors, to ensure that existing services such as outpatient and assessment services (eg Tier 2) work on CATS pathways and service models; this will have the effect of increasing efficiency and the potential to generate additional capacity.

## 4. More extensive use of healthcare market to cover capacity shortfalls

Some shortfalls will be covered through the new CATS capability, in other areas we will need to commission additional new activity as required, from a range of existing or new providers.

## 5. PBC initiatives – Direct access diagnostics, enhanced Primary care

We have already been able to develop primary care direct access to diagnostics in a range of areas such as cardiac care (ECGs and ECHO); resulting in reduced waits, efficiencies and improvements in patient outcomes. With our strong PBC base in Manchester we have the potential to develop further additional capacity and choice. We will ensure value for money by working with secondary care to unbundle diagnostic costs from tariffs.

## 6. Achieving waiting time targets in community services

Waiting times for community services are currently variable. We plan to redesign current services and explore new pathways from a range of providers to modernise our community service provision and ensure maximum efficiencies for our patients.

## 7. 18 weeks access to psychological therapies

Current waiting times for access to psychological therapies vary widely but range on average from 6-18 months in secondary care, with some much shorter waits in primary care. We will achieve our reduced waiting time targets through a combination of service re-design, provider efficiency, and commissioning additional capacity where necessary from the range of providers.

## Investment/disinvestment requirements

The new services will increase capacity and enhance accessibility and patient choice; and in most areas take services closer to home.

There will be a significant impact on acute services, specifically in relation to reduced dependence on hospital outpatient, diagnostics and minor procedure services, which it is felt can be provided in the community with no loss of effectiveness.

The initiative also proposes more extensive use of the range of healthcare providers, and will encourage new entrants into the healthcare market.



Contract plans and assumptions with acute providers will need to be reduced.

## Stakeholder engagement

Clinicians from all sectors have been involved in the work up of the CATS models and development of pathways.

## PCT capabilities required

The required capabilities will include:

- Project management capacity to ensure mobilisation of all projects
- Clinical engagement for pathway development
- Sufficient strong contracting and procurement (note that for PCT CATS the PCT has engaged the services of the Greater Manchester Commissioning Business Service).
- Market intelligence and development
- Performance and contract management

## Implementation Risks

Title	Severity rating	Description of impact	Mitigating actions
Demand on the system continues to rise	M/L	Growing demand makes the system unsustainable and unaffordable	Regular monitoring and action planning relating to adverse variances
Clinical risk of service changes	H	Risk to patients of being treated within new pathways	Clinical engagement in pathway development; clinical governance scrutiny of pathways
Patients and clinicians choose not to use new services and pathways	M	Inefficient system, excess costs, duplication	Strong clinical and public engagement and leadership; promotion of new services and models
Responsive services lead to fall in referral thresholds	M	Excessive growth in demand for new services; cost pressures	Strong service specification, criteria, referral thresholds and protocols. PBC Peer review.

## Strategic Initiative 10

### Improve access to urgent care

This strategic initiative is designed to support the implementation of an urgent care system which is responsive to patient need and demand, is effective and provides value for money, and meets key access and health improvement targets

The strategic objectives will be achieved by the implementation of three major programmes of work:

#### 1. System Reform of Urgent Care

This programme will work to:

- Create a Single Point of Access for clinicians, and potentially patients. This will consist of an information system holding directories of urgent care services, their capacity and entry criteria. Telephone support will be given to referring clinicians or potentially patients in choosing urgent care services and co-ordinating the transfer to them. e.g. a GP referral to intermediate care instead of A&E or a Discharge Manager to homecare support rather than additional bed days.
- Improve information flows between organisations and sectors of care so urgent care can be delivered by any provider and they will have basic information such as medication lists and currently active conditions e.g. COPD.
- Advance the utilisation of technology in the delivery of urgent care e.g. telemedicine in nursing homes or for the housebound allowing more opportunity to assess patients without hospital transfer and avoidable hospital admission.

There is further potential to attain additional benefits through developing a joint approach with Manchester City Council, who have been developing assistive technology to support developments in adult social care.

#### 2. Managing urgent care demand

In order to achieve sustainable access to A&E demand on emergency services will need to reduce over time.

This Programme will enable the development of:

1. improved flows through A&E and emergency pathways within secondary care;
2. improved primary care access;
3. active Case Management;

4. improved discharge to home or community services;
5. improving mental health inputs into the urgent care system; through the introduction of inpatient psychiatric liaison and access to psychological therapies.

#### 3. Increasing capacity and effectiveness in the community

The Improving Health in Manchester programme has already concluded through its work on personalisation of community care that there is a need to invest in community alternatives to acute provision within urgent care – and to transform the system so that more care is planned for and dealt with on a proactive rather than a reactive basis.

Increasing the capacity and effectiveness of services in the community will ensure that more need is met outside the acute sector, and that bed pressures, which block A&E admission, will be supported by early discharge.

This Programme will include:

- The development of integrated service models with the City Council and other key agencies; specifically in terms of models of intermediate care, rehabilitation and reablement services. Where necessary increasing capacity of such services; specifically intermediate care, both at home and in residential settings.
- Increasing capacity in community support services (Case management, Community Falls services and Strokes Early Supported Discharge and Community Stroke teams)
- Investment in preventive services, mainstreaming and building on successful Partnerships for Older People (POPPS) initiatives.

#### How it supports goals

This initiative is designed to support Goal 10; to improve access to unscheduled care.

#### Impact on health inequalities and outcomes

- A more integrated system of urgent health and social care
- Improved patient experience and clinical care
- A reduction in attendances at A&E and demand on emergency services
- A reduction in non elective admissions, readmissions and bed days



- An increase in transfer from A&E into community services
- An improvement in the 4 hour emergency access target
- Improved integration between urgent and planned care services
- A reduction in unnecessary investigations
- A financial saving for investment 'upstream'
- Care being delivered in patient's own home

Impacts will follow the establishment of the new services (with some lead in time required, say between 3 and 6 months).

Other impacts will be dependent on the specific initiatives – eg some Telemedicine inputs will provide immediate patient benefit.

## Impact on activity and finance

The financial impact for this initiative is anticipated to be:

Gross cost:	£4,468,000
Savings target:	£ 10,177,000
Net cost:	-£ 5,709,000

The financial costs and phasing for these are estimated to be as follows:-

### 1. System reform

#### **Single point of access (SPA)**

Set up in quarter 1 2010, so no spend 2009/10.  
£1m per annum recurrent costs from 2010/2011.

It is anticipated that the service will reduce demand on the urgent care system as a whole, and in particular will be able to reduce Emergency Medical Admissions (EMAs). Once fully in place the SPA should be able to reduce EMAs by 250 per annum, making the system self-financing.

*Net costs are therefore estimated as*  
2009/2010 - Nil. 2010/2011 - £1m. 2011/2012 - £500k.  
2012/2013 – Nil.

#### **Information systems**

Set up costs in quarter 1 2010 - £250,000.

Thereafter should reduce length of stay and excess bed days (EBDs) by 1,700 per annum; so again becoming self-financing.

*Phasing as follows:-*  
2009/2010 - Nil. 2010/2011 - £250k. 2011/2012 - £125k.  
2012/2013 – Nil.

### **Telemedicine/New technologies**

Will require initial investment; thereafter can save EMAs and become breakeven (saving of 190 EMAs p.a.)

Initial investment proposed as £500k in 2009/2010, £750,000 in subsequent years. Net costs £500k in 2009/10, nil in subsequent years.

Joint commissioning with Manchester City Council will provide added benefits in this area.

### **2. Managing urgent care demand**

It is proposed that an initial £500k be set aside for investment, which can generate reductions in attendances at A&E. A 1% reduction in attendances can generate savings of £250k, halving the gross investment costs.

#### **Phasing as follows:-**

2009/10 - £500k. 2010/2011 and recurrent - £250k.

The mental health inputs into urgent care have been costed at £2.2m gross; which it is considered can be resourced through the impacts generated, as well as through overall re-design of mental health services.

### **3. Increased capacity and effectiveness in the community**

All services are to be established from 2009/10 and to be recurrent; and all to have impacts in terms of savings from reduced EMAs and EBDs. Additional savings may be able to be generated through provider efficiencies. Specific schemes work out as follows:-

#### **Intermediate Care, rehabilitation, reablement**

£2.2m gross cost; net cost estimated at £1m

#### **Case management**

£2m gross, £1m net

#### **Community falls service**

£700k gross, £275k net

#### **Strokes – Early Supported Discharge and Community teams**

£1.2m gross, £1m net

#### **Prevention initiatives**

The PCT has already approved mainstreaming of the Partnerships for Older People Projects (POPPs), at a cost of £450k per annum; this represents half the cost of the programme, the other half being funded by Manchester City Council.

## Investment/disinvestment requirements

Current urgent care services are organisation focussed and reactive to demand; rather than being proactively commissioned to achieve health improvement.

Therefore the proposals to invest in community alternatives to the current acute focussed model will have direct benefits in terms of health improvement and personalised approach to service delivery.

Specific investment/disinvestment requirements have been outlined in the section above.

## Stakeholder engagement

Engagement has taken place with partners, stakeholders, patients and public.

Examples include

- Qualitative research with patient groups targeted at people with particular conditions (eg respiratory)
- Surveys of users of the urgent care; specifically one of people from minority ethnic communities and another of students
- Talking Health survey of Manchester public specifically focussed on urgent care system

## PCT capabilities required

Identify existing capabilities or new capabilities that may be required to secure successful delivery.

Need to develop procurement function and capability.

Also to gain expertise in use of new technologies for maximum gain for patients and service users.

Title of risk	Severity rating (LMH*)	Description of impact	Mitigating actions
Demand on the system continues to rise	H	Excessive demand makes the system unsustainable and unaffordable	Regular monitoring and action planning relating to adverse variances
Clinical risk of service changes	M	Risk to patients of being treated within new pathways	Clinical engagement in pathway development; clinical governance scrutiny of pathways
Organisational risk	M	Inefficient system, excess costs, duplication	Clear service specifications and referral protocols, contracting and performance management.





## Strategic Initiative 11 – Mental Health

### Mental Health

The commissioning strategic plan sets out the broader context by which we intend to reform mental health services, in pursuit of the Boyington assessment. The series of programmes detailed below summarise the workstreams throughout the first 10 initiatives that have a specific mental health impact.

#### Initiative 1 & 2

The specific work programmes here are the development of the Health Trainers, who will provide support and intervention for people with mild mental health issues, and the Manchester Healthy Living Network, which will benefit mental health patients by promoting aspiration and well-being, supporting vulnerable residents and encouraging partnership working.

#### Initiative 4:

There is a significant proportion of mental health service users who have a co-morbid substance mis-use alcohol problem. This initiative will ensure that problem drinkers have access to early intervention at key points of access to healthcare and that heavy/dependent drinkers attending A&E will be provided with additional support to prevent re-admission.

#### Initiative 6:

Within mental health this initiative will help build capability to support the reduction in avoidable harm and expand training in adverse incident management. This will include investigation skills, as well as training in managing the required changes based on learning and best available evidence.

#### Initiative 7:

Within mental health it has been highlighted that primary care mental health services are a priority. The Manchester Standard represents the quality mark being created for primary care services in Manchester. This will thus enable achievements of outcomes such as improved access, improved and more equitable care of patients with long-term conditions, better prevention, as well as improved safety in primary care.

#### Initiative 8

Programme 3 here focuses on improving the current Crisis Resolution Home Treatment (CRHT) service, to ensure that benefits are realised. Including strengthening community support, reducing the inpatient admissions, reducing the number of A&E attendees and providing a more appropriate service.

#### Initiative 9:

Here we will deliver and sustain the maximum 18 week referral to treatment target; and also extend this to cover all areas of elective services including community services (removing 'hidden waits'); and, in mental health, access to psychological therapies.

#### Initiative 10:

To address the demand management issue within urgent care this initiative will improve mental health inputs into the system; through the introduction of inpatient psychiatric liaison and access to psychological therapies.

### How it supports goals

#### Supports goals:

Goal 1 - To increase the average life expectancy of Manchester residents to 80 years

Goal 2 – To ensure that the city is no longer among the top 5 most deprived local authorities in England

Goal 4 – To halt the expected rate of growth in alcohol-related admissions

Goal 8 - To ensure that all people with long-term-conditions (LTCs) are supported to be independent and in control of their condition maintained by personalised care plans.

Goal 9 - To ensure that 90% of admitted and 95% of non-admitted patients are seen within 18 weeks.

Goal 10 - To ensure that at least 98% of patients spend less than 4 hours in A&E

### Impact on health inequalities and outcomes

See individual initiative

### Impact on activity and finance

See individual initiative

### Investment/ disinvestment requirements

See individual initiative

### Stakeholder engagement in the formation of the initiative

See individual initiative

### PCT capabilities required

See individual initiative

# In-year Monitoring of the Strategic Initiatives

## Strategic Initiatives 1 and 2

### Health people live longer and reduce the gap in health between different communities

#### Key milestones for in-year monitoring

##### Reducing infant mortality

Vital Signs 6-8 week breastfeeding continuous improvement – quarterly, as for Performance Accelerator

The key performance measure will be the number of 4-week smoking quitters. The Stop Smoking Service collects these data quarterly by for return to the Department of Health; they will also be reported to the Smoke Free Manchester Working Group, and via that group to the Adults Health and Wellbeing Partnership.

##### Tobacco control

LDP 4-week quit targets with a quit rate above 35% (NICE recommendation 2007).

2008/09 -4,636

2009/10 – 4,741

2010/11 – 4,845

(targets to be reviewed in 2009 due to 1.4% population rise)

For the Manchester Stop Smoking Service to achieve the target of 5% of the smoking population engaging in offered support, with a view to increase the target to 5-10% by 2011.

##### Cardiovascular disease risk management

###### Milestone 1; Install predictive risk register software

- A software package will be installed on practice systems, enabling key practice staff to estimate individual risk and offer appointments for assessment

###### Milestone 2; READ coding in practice of high CVD risk

- As individual CVD risk assessments are completed, the appropriate READ code will be entered on practice systems.

###### Milestone 3; Define Local Enhanced Service

- A proposed service specification for a local enhanced service for the management of high risk patients will be written

###### Milestone 4; Agree and Implement LES

- The LES specification will be agreed with local providers and contracts put agreed

###### Milestone 5; Screening for CVD risk by other providers

- Contracts will be placed with other primary care and community providers to offer appointments for assessment to individuals who do not access general practice based screening.

###### Milestone 6; Tender for MyAction

- Providers will be invited to tender for the delivery of a community based vascular prevention programme, based upon the MyAction service specification

###### Milestone 7; Implement MyAction

- 9 MyAction programmes will be set up across Manchester, enabling access to high level support for individuals at very high risk and their families in lifestyle change

###### Milestone 8; Establish Cardiac Rehab Steering Group

- The steering group will report to the NHS Manchester CVD prevention steering group

###### Milestone 9; Implement NICE Cardiac Rehab guidance

- Access to existing cardiac rehab provision will be assessed. Disinvestment in poorly performing providers. Commissioning of extra capacity to improve access in areas of low uptake

###### Milestone 10; Deliver Education packages

Packages will be offered in KS 2,3 and 4

#### Cancer

###### Milestone 1; Establish social marketing plan

###### Milestone 2; Deliver marketing campaign

###### Milestone 3; Follow up campaigns

The social marketing campaign will be based upon previously successful models; monitored by a steering group and evaluated independently

###### Milestone 4; Roll out Healthy Communities Collaborative

Utilising existing steering group; targeting wards according to community capacity and health inequalities

###### Milestone 5; HPV Vaccination programme roll-out

Schools based programme, according to national schedule.

###### Milestone 6; Employment of Screening Co-ordinator



Will provide PCT with assurance that quality standards for commissioning of population based screening programmes are met

*Milestone 7; Extension to Breast Screening Programme*

*Milestone 8; Extension to Bowel Screening Programme*  
Requirement of national cancer reform strategy, with prescribed timescales

### Health Trainers

*Milestone 1; Recruit Health Trainers*

*Milestone 2; Training the Health Trainers*

*Milestone 3; Secure involvement of GPs and Practice Nurses*

*Milestone 4; Patients referred*

*Milestone 5; Interim evaluation available*

### Healthy Living Networks

*Milestone 1 – Establish HLN Steering Group; drawing membership from stakeholder group involved in developing business case*

*Milestone 2 - Agree HLN Priorities; agreeing Service Specification in order to proceed to tender*

*Milestone 3 - Establish HLN*

*Milestone 4 Baseline Evaluation Completed*

*Milestone 5 Establish Volunteering Programme*

*Milestone 6 Support roll out of Health Trainer Programme*

*Milestone 7 Establish Cancer Prevention Programme*

### Key metrics for in-year monitoring

#### Infant Mortality

Average Life Expectancy at birth (in years) for men and women combined

Tobacco Control

- Number of smokers seen  
4-week quit rates
- Number of pregnant women seen  
Number of 4-week quit rates in pregnant women
- Number of young people seen  
Number of 4-week quit rates in young people
- Number of BME community seen  
Number of 4-week quitters in BME communities.

Figures for age ranges and gender will also be available.

Other metrics will include:

- Equity of access to services within targeted areas via a health Equity Audit
- Number of statutory and non-statutory services engaged in the scheme
- Number of workplaces engaged in the scheme
- Number of media hits
- Smoking prevalence rates – if available

### Cardiovascular Disease

*Risk Registers*

1. Number of practices with predictive risk registers in place
2. The percentage of patients with a CVD risk score (using an accredited tool) >20%

*LES*

3. % of patients with a CVD risk score >20% whose blood pressure and cholesterol are recorded and are within normal limits
4. % of patients with a CVD risk score >20% who are prescribed appropriate medication
5. The percentage of patients with a CVD risk score >20% with a recorded BMI
6. The percentage of patients with a CVD risk score >20% with a recorded smoking status, have been prescribed smoking cessation products and who have a record stopped smoking

*MyAction*

7. % of patients not smoking  
% of patients compliant with dietary, alcohol, medication and physical activity recommendations measured by self-report and observation of defined anthropometric measures

### Early Detection and Prevention of Cancer

- Prompted recall of social marketing campaigns (survey)
- Spontaneous recall of key campaign messages (survey); For social marketing the surveys must be undertaken at the end of the planned campaign or straight after it has finished
- Involvement of local people in community development initiatives (volunteers and recipients)

- Increase in referrals from primary to secondary care from priority wards (Data collection in GP surgeries)
- Coverage of HPV vaccination; % of eligible population receiving vaccination according to schedule
- Uptake of screening programmes in relation to national standards; % of eligible population offered and accessing screening

Social marketing campaigns and community development initiatives will be monitored by Manchester versus Cancer steering group.

Performance of population based screening programmes will be monitored by cancer specific steering groups and detailed in performance report to PCT board.

### Health Trainers

Quarterly monitoring will be provided to both the Manchester Delivery Group and Manchester Health Trainer Steering Group. This information details the numbers and other demographics of clients, the pre existing lifestyle behaviour of clients and behaviour changes which develop over time with each client. Annual reporting is further required by the NHS Manchester Public Health Directorate for the Public Health Annual Report, The Department of Health and the Greater Manchester Health Trainer Hub.

### Healthy Living Networks

To date there is not a definitive method or system used for the collection of monitoring data from multi-faceted health promotion and community engagement services. Consequently a triangulated approach will be used to monitor the performance of the HLN, using the following methods (these are not exhaustive):

### Lorenzo System

This mandatory NHS system will record and monitor patient and client data in the following ways for some staff groups within the HLN who have direct contact with patients:

- Face to face patient and client contacts /activity.
- Group contacts
- Training and events.

The information can be collected and collated numbers of contacts can be recorded and staff can use the daily diary planner to record their work. The Lorenzo system is limited in the type of information it can record.

### HLN database

A database will be used to record and register all client activity within the HLN; this will show the client journey. For instance when they registered and what activities they have done, exercise class, cooking skills, training or volunteering. The client will have the option of attending a one off activity or longer-term participation in the planning and delivery of services.

The data base will register, partner agencies, CVS groups and individuals and be used to network and share health information.

### Evaluation work

This will be central to showing how the HLN is performing and will take numerous approaches, which will be guided by the steering group and health intelligence sources.

Discreet projects within the HLN will be chosen and evaluated using a variety of tools which are currently being developed as part of the evaluation process, but essentially uses a mixture of qualitative and quantitative methods such as interviews, questionnaires and focus groups to establish:

Community engagement in health related activities and local decision making improvement in health and well-being, community cohesion, participation and partnership working.

## Strategic Initiative 3

### Reduce the number of teenage conceptions

#### Key milestones for in-year monitoring

#### Programme 1: Clinical Outreach in Hotspot Wards

##### 1. Commission service

Funding has been secured to establish clinical contraception and sexual health services and commissioning will occur in Q3.

##### 2. Commence service in 6 locations

The successful provider(s) will be required to establish six clinic sessions per week during Q4, to be delivered in hotspot wards / on further education sites.

##### 3. Commence service in the remaining locations.

The successful provider(s) will be required to establish a further six clinic sessions per week during Q1, to be delivered in hotspot wards / on further education sites.

##### 4. Maintain service provision.

The successful provider(s) will be required to maintain service provision as per the agreed service specification.



**Programme 2 Prevention Team***1. Investigate options for funding service.*

This is a new initiative. Options for funding the proposed prevention team will continue to be pursued during Q3 and Q4

*2. Recruit prevention team*

Subject to funding, recruitment to the prevention team will take place during Q1 Y2

*3. Prevention team to work with 100 clients per quarter*

Team to receive referrals and work with at least 150 clients during Q2

*4. Prevention team to work with 300 clients per quarter.*

Team to work with 300 clients per quarter from Q3 onwards, working with those young people considered at-risk of teenage pregnancy and referred via the CAF.

**Programme 3: Teenage Pregnancy Programme***1. Coordinate teenage pregnancy programme*

Coordination of programme to be maintained in line with locally agreed arrangements; to include at least one meeting of the Board and each of the sub-groups per quarter.

*2. Commission prevention services*

Prevention services commissioned in line with investment plan. Ongoing.

*3. Prevention services monitored*

Commissioned services monitored on a quarterly basis in line with LIG grant conditions and MCC procedures. Ongoing.

Seek funding to maintain teenage pregnancy programme

*4. Local Implementation Grant is due to end at the end of 2010/11*

Options for maintaining the programme at the same level of funding, or to reduce or increase funding, need to be considered and resolved during Y3.

**Key metrics for in-year monitoring****Programme 1**

Number of outreach sites established

Number of young people attending, per quarter

Number of young people receiving contraception, including LARC.

Number of young people receiving sexual health screening

**Programme 2**

Is the service funded / commissioned?

Number of clients seen by staff team

**Programme 3**

Programme monitored in line with MCC procedures.

**Strategic Initiative 4****Reduce the number of alcohol-related hospital admissions****Key milestones for in-year monitoring**

The key milestones for the A&E intervention will include the establishment of the programme in the 3 A&E departments and agreement of quarterly monitoring returns. This will include data on screening and BI delivered plus progress on identifying, tracking and supporting frequent attenders.

An interim evaluation will be produced after one year and a full evaluation at 2 years to justify continued investment.

The primary care screening and brief intervention programme will require identification of the 20 practices willing to participate plus agreement of the patient cohorts to be targeted. Monitoring will be agreed for the practices, training delivered and an evaluation plus recommendations for roll out after the initial 6 month pilot.

**Key metrics for in-year monitoring**

Directly standardised rate of alcohol related admissions per 100,000 population

**Strategic Initiative 5****Reduce the number of children who are overweight****Key milestones for in-year monitoring****Programme 2**

- Procure external support.
- Provide staff development.
- Monitor uptake and engagement.

**Programme 3**

- Recruit staff.
- Deliver training sessions.
- Deliver community sessions.

**Key metrics for in-year monitoring**

National Child Monitoring Programme (annual measure YR and Y6 pupils).

Lorenzo system outputs.



## Strategic Initiative 6

### Make sure health services are safe

#### Key milestones for in-year monitoring

##### *a) Building Capability*

In year 1 we will develop local training opportunities and develop a safety plan with providers

In year 2 we aim to establish a local network for patient safety

##### *b) Implementing Best Practice*

In year 1 we will implement a development plan for the Trigger Tool Analysis team

##### *c) Preventing Never Events*

In year 1 we aim to prioritise the never events list and plan risk assessments for the high priorities; establish never event reporting and; complete risk assessments for the priority never events

In year 2 never event mitigation plans will be developed following completion of risk assessments

In year 3 the baseline for never events will have been determined

##### *d) Resourcing Patient Safety*

In year 1 the team will be recruited; a quality profile for MCH will be developed; the review processes for other providers will be refined and; a risk assessment process established for new initiatives

In year 2 we aim to have developed a measure for avoidable harm and delivered quality profiles for other providers

##### *e) Control of Infection Team*

In year 1 the additional members of the CICT team would be appointed and the assessment of infection control standards would be completed. Training programmes would commence to support development needs.

In year 2 the audit programme would review success of year 1 and the cycle of assessment, training and audit would begin again continuing into years 3, 4 & 5 to achieve target reductions in HCAs.

#### Key metrics for in-year monitoring

The key metric to be measured is the number of C Difficile infections, with an aim to reduce by 45% in line with national targets.

## Strategic Initiative 7

### Improve the quality and availability of primary care

#### Key milestones for in-year monitoring

##### *a) Procurement of GP Practices*

Additional practices will open by quarter 2 of 2009

##### *b) Procurement of NHS Dental Services*

New practices and additional sedation & emergency care will be open by quarter 3 of 2009

##### *c) Extended GP Hours*

We aim to have a baseline at the start of April 2009 of 50% uptake of the DES scheme. Overall the target for year 5 is to have 70% uptake

##### *d) Reducing demand and streamlining access*

For the minor ailments scheme we aim to have the sites live by the end of March 2010 and aim to achieve 100% uptake by the end of March 2010

##### *e) Development of the Manchester Standard*

For GPs and Pharmacists we aim to have core standards implemented by end of 2009/10 and developmental standards by end of year 2 - 2010/11.

For Dentists and Optometrists we aim to have core standards implemented by end of year 2 - 2010/11 and developmental standards by end of year 3 - 2011/12

#### Key metrics for in-year monitoring

% of Patients reporting they can access a GP appointment within 48 hours

## Strategic Initiative 8

### Make sure patients with a long term condition have a personalised care plan

#### Key milestones for in-year monitoring

- Develop LTC Strategy Development
- Review pilot findings for prescription
- Roll out prescription programme if applicable
- Audit existing PCP usage
- Develop healthy lifestyles and self strategy
- Clinician training programme
- Identify LTC for years 3 to 5
- Audit expert patient training programme outcomes
- Roll out expert patient programme if applicable





**Key metrics for in-year monitoring**

% Patients with diabetes in whom the last HbA1c is 7.5 or less

**Strategic Initiative 9****Improving Access to Planned Care****Key milestones for in-year monitoring****Programme 1 – 5 IS CATS**

Initial establishment planned for February 2009; will require approximately 6 months 'ramp up' to full capacity. Demand and referrals may take some time to reach full capacity.

**Programme 2 – PCT CATS**

*Ophthalmology* – CATS Initial establishment Q2 2009/2010; again will take some 6 months for full capacity and demand.

Extended primary care optometry service in place by Q4 2009/2010.

*Dermatology* – CATS initial establishment Q2 2009/2010. Defined primary care model in place alongside, to involve pathways and GP education.

*Dental* – Framework agreement in place by Q1 2009/2010; PCT procurement through that agreement Q 3 2009/2010; new service in place Q4 2009/2010; ramp up of new service through to Q2 2010/2011.

**Programme 3 – PBC Direct access diagnostics and enhanced Primary care**

Ongoing initiatives through 3 PBC hubs; with greater citywide cross hub co-operation, and joint working and service development. Examples to include localised Tier 2 type services etc.

**Programme 4 – Work with Acute sector to reform outpatient and diagnostic services**

Work with providers on specifying service models, agreeing price systems, process for managing service changes, agreeing and evaluating business cases, procuring new service models. Can start in early 2009/2010 (dependent on interest from providers) and from then be ongoing.

**Programme 5 – Use of plural healthcare market to tackle capacity shortfalls**

Ongoing as required. Some market development may be needed.

Capacity plans which will identify risks, gaps and shortfalls to be in place by beginning of 2009/2010.

**Programme 6 – Waiting times for community services**

Task 1 is to establish baseline (currently in progress).

Task 2 to prioritise and agree with provider programme of work (to be done by Q1 2009/2010.)

Task 3 to identify what is needed to achieve waiting time targets (ie service re-design, new capacity or commissioning from alternative suppliers); and to develop Commissioner driven Action Plan; to be done by Q2 2009/2010.

Task 3 to implement requirements from above; this will take a further year and will involve resource identification, specification of provision, service re-design, possible commissioning new or different capacity, development and assessment of business cases, etc.

Overall target to be achieved by end Q2 2010/2011.

**Programme 7 – Access to Psychological therapies**

As per initiative 6.

**Key metrics for in-year monitoring**

**Year 1:** Monthly monitoring of RTT times to achieve and sustain a maximum wait of 18 weeks from referral to treatment for elective care for 90% of admitted and 95% of non-admitted patients, which will be delivered month on month at least 11 months out of 12 at each provider.

Metrics to be reviewed at end of year one to ensure still appropriate to achieve desired outcomes.

**Strategic Initiative 10****Improve access to urgent care****Key milestones for in-year monitoring****Programme 1 Single point of access and information systems**

Projects to be established during 2009/2010 to design requirements and draw up specifications and develop systems for procurement to start new initiatives by early 2010/2011.

**Programme 2 - Telemedicine**

As above – scoping and specification and procurement stages during 2009/2010 for full implementation in 2010/2011.

**Programme 3 – Demand management**

Initiatives focussed on 3 PBC hubs and acute trusts – ongoing, can be in place in early 2009/2010 (informed by key impacts as proposed by KPMG and Dr Foster service reform projects)

#### **Programme 4 – Mental health psychiatric liaison and inpatient therapies**

Phasing and milestones to be added; implementation to be incorporated into PCT overall action plan in light of Boyington Report.

#### **Programme 5 – Community services (Intermediate care, case management, falls, strokes, prevention)**

Initiatives currently being developed as part of Improving Health in Manchester; and so can be in place for the start of 2009/2010; impacts will be measured and monitored during the period of the Plan.

#### **Key metrics for in-year monitoring**

Sustainable Achievement of the 4 hour emergency access target with 98% of all A&E attendances admitted, discharged or transferred within 4 hours of presentation; at each provider and for each month.

Related metrics which are key components of the overall objective and vision include Emergency Medical Admissions, Length of Stay and Excess bed days.



## Strategic Initiative Milestone Plans - Strategic Initiatives 1 and 2

[illegible]

Initiative 1 & 2 - Life Expectancy & Health inequalities	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Manchester Community Health Trainers											
Task 1p - Recruit & Train Health Trainers - involve GPs and nurses											
Manchester Healthy Living Network											
Task 1q - Establish steering grp, priorities, HLN & Volunteering Programme											
Task 1r - Establish Cancer Prevention Programme & Produce evaluation report											

## Strategic Initiative 3

Initiative 3 - Under 18 Conceptions	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Clinical Outreach											
Task 3a - Commission service											
Task 3b - Commence service in 6 locations											
Task 3c - Commence service in remaining locations											
Task 3d - Maintain service provision											
Prevention Team											
Task 3e - Investigate options to fund service											
Task 3f - Subject to funding, recruit prevention team											
Task 3g - Prevention team to work with 100 clients per quarter											
Task 3h - Prevention team to work with 300 clients per quarter, ongoing											
Teenage Pregnancy Programme											



[illegible]

## Strategic Initiative 4

[illegible]

Initiative 4 - Alcohol related admissions	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Task 4m - Provide recommendations for roll out											

## Strategic Initiative 5

Initiative 5 - Childhood Obesity	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Family centred lifestyle support for the under 5s											
Task 5a - Procure external support											
Task 5b - Recruit staff											
Task 5c - Train staff											
Task 5d - Begin programme delivery											
Community Food Workforce expansion											
Task 5e - Recruit staff											
Task 5f - Commence service delivery											
Task 5g - Monitor progress											
Task 5h - Review delivery programme and targeting											

## Strategic Initiative 6

Initiative 6 - Avoidable harm	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
BUILDING CAPABILITY:											
Task 6a - Develop patient safety plan with providers											
Task 6b - Develop training opportunities locally											
Task 6c - Establish local network for patient safety											
IMPLEMENTING BEST PRACTICE:											
Task 6d - Development plan for TTA team post Year 0											





[illegible]

## Strategic Initiative 7

[illegible]

Initiative 7 - Improving access to and quality of primary care	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Task 7e - Define and implement Core Standards for GPs & Pharmacists											
Task 7f - Review & inspect core standards in practice											
Task 7g - Define & implement developmental Standards											
Task 7h - Review & Inspect developmental standards in practice, & evaluate improvements											
Task 7i -Appoint Optical Advisor											
Improving Access											
Task 7j - Procurement of GP practices and GP led HC, and implementation of extended hours											
Task 7k - Procurement of routine activity and urgent care NHS Dental activity											
Task 7l - Minor ailment scheme community pharmacy											
Task 7m - Repeat dispensing											

## Strategic Initiative 8

Initiative 8 - Personal care plans	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Task 8a - Develop Long term conditions strategy development											
Task 8b - Agree priorities for 08/09 commissioning intentions, i.e. LTC											
Task 8c - Develop healthy lifestyles and self strategy											



[illegible]

## Strategic Initiative 9

[illegible]

## Strategic Initiative 10

Initiative 10 - Access to unplanned care	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Task 10a - Develop single point of access and information systems											
Task 10b - Introduce telemedicine/new technologies											
Task 10c - Control demand management											
Task 10d - Mental health psychiatric liaison/therapies											
Task 10e - Intermediate care, rehab, reablement											
Task 10f - Case management											
Task 10g - Community falls service											
Task 10h - Strokes early supported discharge and community teams											
Task 10i - Prevention - POPPs											

## Strategic Initiative 11

Initiative 10 - Access to unplanned care	2008/09				2009/10				2010/11	2011/12	2012/13
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Task 11a - Devise action plan re: Boyington Report											
Task 11b - Consolidate commissioning intentions in primary care and community settings											
Task 11c - Renegotiate mental health acute sector contracts											



# Glossary of Terms

A&E	Accident and Emergency – also known as ‘casualty’, the hospital department designed to deal with urgent, serious and life-threatening illness and injury
AAACM	All Age All Cause Mortality – a fundamental measure of a population’s health risk factors, prevalence and severity of disease
AGMPCTs	Association of Greater Manchester Primary Care Trusts – a collaborative arrangement involving Greater Manchester’s ten primary care trusts to assist coordination and maximise opportunities to work across a wider footprint
CATS	Clinical Assessment, Treatment and Support services – services commissioned to improve patient care by offering additional capacity and choice for patients referred by their GP for a range of conditions
CLG	Communities and Local Government Department (central government)
CSP	Commissioning Strategic Plan – this document, a five-year plan setting out NHS Manchester’s approach to improving health
DSR	Directly Standardised Rate – figures adjusted to account for different age structures among different populations
EMT	Executive Management Team – NHS Manchester’s Executive Directors and Professional Executive Committee Chair
HCAI	Healthcare Associated Infections – infections that are acquired by patients in hospital or through other healthcare interventions
IMD	Index of Multiple Deprivation – a guide to the extent of different forms of deprivation by local authority ward-level
KSF	Knowledge and Skills Framework – identifies the knowledge and skills NHS staff need in their post, guiding individual development and performance
LAA	Local Area Agreement – 3-year agreement setting out the priorities for the locality, as agreed between central government and the locality via the Local Strategic Partnership
LSOA	Lower Super Output Area – smaller, sub-district geographical areas for which a range of health-related data is available
LSP	Local Strategic Partnership – non-statutory, multi-agency partnership involving public, private, voluntary and community sector organisations working together to achieve shared goals on behalf of their communities
MCH	Manchester Community Health – NHS Manchester’s service provision arm, which delivers a range of health services including district nursing and health visiting
NWSCG	North West Specialised Commissioning Group – body responsible for commissioning a range of specialist health services, using funding contributions from the region’s primary care trusts

OD Plan	Organisational Development Plan – describes NHS Manchester’s approach to developing its culture, capabilities and structures to contribute to achieving its overall goals
OSC	Overview and Scrutiny Committee – Manchester’s Health and Wellbeing OSC is a statutory function that empowers elected members, through the local authority, to scrutinise local strategies and service provision for health and wellbeing
PBC	Practice Based Commissioning – a national approach to delegating greater responsibility to GPs and other clinicians in redesigning services to meet their patients’ needs
PbR	Payment by Results – a national system by which NHS trusts are paid, via primary care trusts, for the quantity and type of care they provide
PCT	Primary Care Trust – organisation responsible for improving health, primarily through using funds received directly from central government to commission effective local healthcare and be the local leader of the NHS
RTT	Referral to Treatment Time – timescale from GP referral to treatment commencing
SLT	Senior Leadership Team – senior managers of NHS Manchester including those at Director level and those who report to Directors
SSDP	Strategic Service Development Plan – sets out approach and priorities for improving primary care buildings and facilities.
WCC	World Class Commissioning – national programme to deliver outstanding performance by primary care trusts in the way they commission health and care services on behalf of the NHS. This plan forms an important part of NHS Manchester’s assessment against the World Class Commissioning assurance framework.







