Date: 31 March 2017

Subject: Personalisation and Choice in Greater Manchester

Report of: Steve Wilson, Executive Lead: Finance & Investment, GMHSC Partnership

PURPOSE OF REPORT:

The purpose of the report is to update the Strategic Partnership Board on the work done to develop an approach to personalisation and choice across GM. The paper outlines a proposed approach to developing a programme to deliver integrated personal commissioning across GM and with localities.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Note the content of the report
- Feedback on the proposals contained in the report
- Approve the proposed next steps in developing this work

CONTACT OFFICERS:

Steve Wilson, Executive Lead: Finance & Investment, GMHSC Partnership
steve.wilson6@nhs.net

Zoe Porter, National Delivery Lead, Integrated Personal Commissioning and Personal Health Budgets at NHS England
zoe.porter@nhs.net
Personalisation and Choice in Greater Manchester

Briefing for SPB 31st March 2017
This slide pack proposes an ambitious Personalisation and Choice Programme across Greater Manchester to include Integrated Personal Commissioning (IPC), personal health budgets and embedding of Choice policy taken to scale across the Partnership.

**Case for change**
- What is the problem we want to solve in Greater Manchester?
- Case for personalisation and choice as part of the solution

**What the change could look like**
- Integrated Personal Commissioning as a framework to shift choice and control for people with the highest needs
- Choice Planning framework as a tool to help a wider population to exercise meaningful choice in respect of their care and treatment

**Proposed approach in Greater Manchester:**
- Alignment with existing programmes
- Our ambition
- Priorities

**Supporting delivery:**
- What can we build on?
- Greater Manchester toolkit – our framework for delivery
- Resources
- Evaluation
- Next steps
Case for change
The problem to be solved?

- GM is the fastest growing economy in the country, but people die younger here than people in other parts of England.
- Nationally 70%+ of NHS spend is on treating people with long term conditions, and GM has a high prevalence.
- 66% of people who are aged 65+ live with 2 or more conditions (nationally) and the GM older population will increase by 25% by 2025.
- More people with multiple long term conditions means the system has to get better at helping people live with chronic ill health.
- Thousands of people are treated in hospital when they really don’t need to be; care between teams is not always joined up and not always the right quality.
- 44% of the population (nationally) do not share decisions about their treatment, care or support.
- 35% of people (nationally) with long term conditions have no or little confidence to self-manage.
Part of the solution will come about through harnessing the power of the people of Greater Manchester through real personalisation

Building people’s skills & confidence to improve health & shape care

Intensive long term health & social care users

Person centred care and support planning; peer support; self management & community capacity

Higher ‘PAM’, shape own care, less demand

Services & commissioning shifts control to people, families & advocates

Fractured, crisis driven services that don’t fit round lives & create dependency

Power shift to individuals, families advocates & voluntary sector

Personalised services that are better designed for complex lives, & reduce dependency
Personal health budgets (see right) are underpinned by **personalised care and support planning**. Personalised care and support planning on its own is likely to also offer benefits to the person, particularly around their experience of care.

For example, a RAND study on behalf of the World Health Organisation noted a range of benefits from coordinated care planning approaches, and that the intervention was cost neutral. This covered people with depression, diabetes and heart conditions. In England, the Year of Care programme for people with diabetes produced similar findings.

**Peer support**: There is robust evidence generated by LSE on behalf of the Centre for Mental Health for peer support in mental health. It tentatively estimates a benefit:cost ratio of 4.76:1, found through reduction in bed usage over an average of a 12-month period. Investment was, on average, of the order of £30k.

**Local area coordination**: good economic evidence has been produced by the Personal Social Services Research Unit (PSSRU) and summarised by Think Local Act Personal. The estimated health and care economic benefit per annum per person is £900. Typical benefits included reduced use of GPs, reduction in referral to social work assessment teams, and reduced use of day service provision. Costs vary, but are typically in the £100-£300 range. A conservative estimate of net benefit is therefore £600 per person per annum.

**Personal health budgets** were piloted between 2009 and 2012. 20 PCTs took part in a controlled trial involving over 2,000 people. The evaluation considered outcomes, use of health services, costs and cost-effectiveness, and collected information from people over up to 18 months. The main findings were:

- Personal health budgets improved people’s care-related quality of life and their psychological wellbeing.
- For the whole sample, personal health budgets were generally cost-neutral, with some sub-groups demonstrating cost reductions.
- For people with high levels of need, personal health budgets improved some outcome measures and maintained others, while also reducing their costs (estimated to be around £3,100 per person, generally in-patient costs).
- For people who had more choice and control, outcomes tended to increase by more than for those who had less choice and control.
What the change could look like
What the change could look like

At our first engagement event on 8th March 2017 Gavin and Karen Croft explained how difficult it had been at times to get real choice and control from the health and care system, and what a positive impact it had for them (and the system) when it was in place. With

- a strong leadership commitment,
- a concerted effort across GM and
- attention to what would make this work for everyone

thousands of GM citizens could experience the benefits, without needing to fight so hard.
What could we use?

- Over the last few years the Integrated Personal Commissioning programme has been working with 18 areas to take personalisation to scale.
- The learning so far from these areas provides a helpful broad framework and set of approaches we could use and adapt in Greater Manchester to fit our specific context and ambitions.

**Integrated Personal Commissioning (IPC)** builds on personal health budgets and personal budgets in social care:

- Brings together funding from education, health, and social care for people with complex needs enabling them to direct how the combined resources are used for the first time.
- Requires a different approach to planning and commissioning community, social care and other services to deliver person-centred, coordinated care at scale for target populations.
- Explicitly aims to harness community capacity, grow social capital and enhance the role of VCSE sector.
Key features of IPC

The key features describe what people can expect to happen when they are offered IPC.

A person should:
- Be able to access information and advice that is clear and timely and meets their individual information needs and preferences
- Experience a coordinated approach that is transparent and empowering
- Have access to a range of peer support options and community based resources to help build knowledge, skills and confidence to manage their health and wellbeing
- Be valued as an active participant in conversations and decisions about their health and wellbeing
- Be central in developing their care plan and agree who is involved
- Be able to agree the health and well-being outcomes they want to achieve, in dialogue with the relevant health, education and social care professionals

If this leads to a personal budget, a person should:
- Know upfront an indication of how much money they have available for healthcare and support
- The amount of money in the budget must be sufficient to meet the identified health, wellbeing and education needs and outcomes agreed in the care plan
- Have the option to manage the money as a direct payment, a notional budget, a third party budget or a mix of these approaches
- Be able to spend the money to meet their outcomes in ways and at times that make sense to them, as agreed in their plan.
Integrated Personal Commissioning Operating Model

**5% of Population**
- Cohorts identified on the basis of local priorities and need

**Proactive or Reactive Referral Routes**
- GP referral (proactive - by population risk stratification)
- GP referral (reactive - by person presenting who could benefit)
- Specialist or acute health services
- Hospital discharge and intermediate care (post reablement)
- Social care (childrens and adults)
- Voluntary, community and social enterprise (VCSE) organisations
- Self-referral

**Proactive Coordination of Care**
People proactively or reactively identified and offered information about IPC. Multi-disciplinary IPC hubs with single points of coordination for each person.

The 3 middle elements are parallel processes that don’t necessarily happen sequentially; people can experience one, two or all of them at any one time depending on their personal circumstances and current priorities, level of need, referral route, eligibility, appropriateness etc.

**Community Capacity and Peer Support**
Make the most of what’s available to you through Local Area Coordination and systematic access to peer support.

**Personalised Care and Support Planning**
Have a different or better conversation to identify what matters to you, and capture this in one place.

**Personal Budget**
A personal budget blends resources to achieve health, wellbeing and learning outcomes.

**Making it Happen**
Accessing a wider range of care and support options tailored to individual needs and preferences, through personalised commissioning and payment.

**Review**
Part of personalised care and support planning. Check how well everything is working and adjust the plan and budget. Explore other elements of IPC offer that have not yet been considered, and repeat.

**Finance Enablers**
- Cohort ID
- Cost of individual services
- IT solutions
- Linked data
- Person-level costings

**Workforce Enabler**
(underpins everything):
- Workforce capacity planning
- Multi-disciplinary team options
- Workforce development plan

**Leadership, Co-production and Change Enabler**
(underpins everything):
- Clear system leadership
- Vision, strategy and action plan for change
- Communication strategy

**IPC Key Shifts (colour coded)**
- Proactive coordination of care
- Community capacity and peer support
- Personalised care and support planning
- Choice and control
- Personalised commissioning and payment
The Optimising Choice programme can bring the benefits of personalisation to a wider cohort

**Supporting people, carers and families to exercise meaningful choices**

- People are able to discuss options with their GP/referrer and have time to decide on the right treatment for them.
- People are able to choose a provider based on what is important to them.
- People are not forced to wait too long for treatment and are easily able to move to a provider who can treat them quicker, if they wish.
- People are able to access and understand the information available and can make informed choices to tailor their care to their needs.
- People experience of services is better, they are more engaged in their care and experience better outcomes.

**Supporting providers to meet their RTT standards by helping spread and reduce the demand for elective services**

**Supporting commissioners by demonstrating how meaningful choice can add value to them using the CCG planning guide**

**Supporting place based approaches to meaningful choice – developing person and community centred approaches at scale**

**Choice outcomes: for your population**

- Improved quality and safety, with people choosing the best services creating a "pull" for others to improve, which will drive system transformation
- Spread demand across the system: if people prioritise waiting times, then demand will spread with potential benefits for access targets
- Increase in the number, range & uptake of community/self care options available to patients and as a result reduce demand on existing services
- Providing a rich source of information on patterns & trends to support robust forecasting and effective commissioning.
- Support of priority initiatives for example; GM transformation agenda, RTT, Information & Technology, Mental Health, e-RS, New Care Models

**Choice outcomes: for your systems**
Do we know whether all of our patients are being offered meaningful choice? If not, what can be done to improve our knowledge?

Are we doing enough to build choice into our commissioning plans and the services we commission?

Are we adequately promoting choice to our patients?

Are our clinical pathways, GP/referrer processes and protocols good at offering and facilitating choice?

How can we make the most of the opportunities provided by devolution and new care models to make meaningful choice a reality for all of our patients?
Proposed approach in Greater Manchester
Alignment with existing programmes

- Adult social care reform
- Incentivising Reform
- End of Life SCN Programme
- RightCare
- CHC Improvement Programme
- Transforming Care

**Personalisation and choice programme enhancing and supporting delivery of GM’s programmes. Operating through “Transforming Community Based Care and Support”**

**With key dependencies with “Enabling Better Care”**
Our ambition

- To be developed through series of discussions and wider engagement events (first one held 8th March) and through further decision making
- Vision to be developed that sets out the tangible change in peoples’ experience of getting support, and ability to take more control
- Practical shifts in how support in Manchester is configured and delivered to people so that we can articulate something like:
  - By 2020/21 to develop a fully integrated person centred model of care for the 140,000 people in Greater Manchester with the most complex needs including:
    - 20,000 people getting personal health budgets or integrated personal budgets
    - Genuine person-centred planning conversations to be happening with 100,000 people
    - 140,000 people to have access to community asset based approach and peer support
  - Every area to have in integrated health and social care personal budgets delivery system
  - Every CCG to have an improvement plan in relation to Choice policy
Early priorities

We have identified 3 groups of people to focus on in the early phases: people with a learning disability, people getting end of life care, and people with long term conditions.

It is proposed that for 2017-19 we use structured innovation methods to identify specific, ambitious, action oriented goals. Leaders across GM support their frontline staff to make tangible short and medium term progress with these, alongside a long term strategic programme.

For example:

- **People getting end of life care** – we want everyone across GM with an expected death to experience a genuinely person centred advanced planning conversation (2015 data = 18,000 adults)

- **People with long term conditions** – Everyone with very complex needs living at home can design individual bespoke support that reflects what is important to them - people getting NHS CHC and joint funded packages all getting a personal health budget (1,500 people)

- **People with a learning disability** – everyone getting jointly funded health and social care support gets one integrated personal budget planned around what it would take to have a good life. Other goals to be agreed.

- **Choice Rights**: every CCG to have an improvement plan for Patient Choice
Integrated Personal Commissioning

Supporting delivery
Greater Manchester toolkit – our framework for delivery

Combined system redesign and transformational change programme building on existing knowledge, skills and progress:

• A collaborative development process across Greater Manchester to develop critical deliverables through **innovation teams**, with an agreement to testing them in front-running localities before being adopted across the full area.

• Running alongside a **supportive change programme** for key managers and staff to give them the time, space and support to lead the practice and behaviour changes required.

• Led by embedded personnel from across GM, supported by a small central team, and co-designed and delivered with people with lived experience.
Delivery programme structure

**Executive sponsors**
*Profile, status, urgency, learning agenda*

**Leadership group**
*Set challenge, empower teams, break bureaucracy, hold learning agenda.*

**Innovation team 1**
Community test adopt, adapt.

**Innovation team 2**
Community test adopt, adapt.

**Innovation team 3**
Acute test adopt, adapt.

Central GM team, plus NHSE external expertise and advice

Insights/learning
Enable/Enterprise

Supportive change programme to support reflective practice and build skills and confidence

Adapted from Nesta 100 day challenge structure
Resources

Resources for Phase 1: Full baselining, feasibility and scoping work: staff team (7wte) to be coming into post over period, non-pay costs for venues, small amounts of time from locality staff - £250k

Resourcing for future stages to be undertaken and agree as part of Phase 1, but to include funding for:
- Backfill time to give capacity to localities to lead this work
- Biddable innovation pot for areas willing to develop and test new models
- Central programme team
- Investment in co-production with people with lived experience, and time from VCSE partners
- Central development and support programme
Evaluation

- To be designed as part of full scoping work
- Key indicators to be developed, such as reduction in use of particular services; people getting to die at a place of their choosing; people making better use of the resources available to get a better quality of life.
- Suite of tools available from the national IPC programme – currently using ASCOT, EQ5D, Warwick-Edinburgh
- Other available, such as PAM scores, POET tool
- Development of linked dataset to enable integration, plus also to track whole system costs
What will Greater Manchester need to do?

• Gain commitment across the system at a senior leadership, frontline and community level.
• Back up this commitment through assurance and performance processes
• Support this across other programmes, eg the establishment of LCOs to be configured to enable this change
• Establish the system leadership through a Leadership Group
• Incentivise and enable this through Transformation funding
Next steps

- Creation of a Leadership Group by May 2017
- Full baselining and feasibility project by August 2017, and immediate actions to get early alignment with incentivising reform programme, and the development of LCOs.
- Formal programme initiation September 2017
- Creation of a central programme team, and freed up time from embedded personnel in localities, coming into post April – September