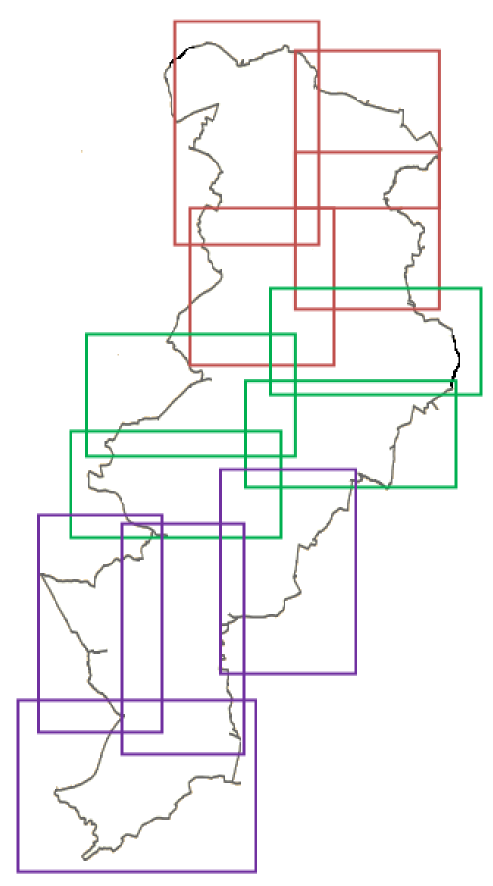
Living longer, living better

ONE Team

Place Based Care



Specification – 2020 Design

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INTRODUCTION

This document outlines the design specification from a commissioner perspective for the One Team – Place Based Care model for community based care in the City of Manchester. The model will be the basis on which we seek to see the realisation of the Living longer, living better strategy.

Section One describes the background and context to this work outlining the challenges Manchester faces in terms of health and wellbeing and the key strategies in place to meet those challenges.

Section Two describes the specification for One Team – Place Based Care as the means by which we grow community based care and make the shift from a system which has too much reactive, expensive and institutional care to one which enables, encourages and promotes health and well-being through place-based, integrated working that prevents ill health and keeps people living well in their community.

The specification outlines the key features of the model setting out clear design parameters and the outcomes commissioners seek to improve as a result.

Section three describes the next steps for implementation and specifically a new approach to commissioning which invites existing providers and stakeholders in Manchester to work collaboratively to move toward this new model of care.

This is a joint specification of the following commissioning organisations:-

Manchester City Council
NHS North Manchester CCG
NHS Central Manchester CCG
NHS South Manchester CCG

It should be read in conjunction with the Living longer, living better strategy, the One Team - Place Based Care vision. In addition to this document there are a number of supporting documents. All of these documents are listed in appendix one and are freely available.

SECTION ONE - BACKGROUND

1. The City of Manchester

Manchester is a vibrant, dynamic city with a growing population. The city has world class commercial, cultural, sporting and academic assets as well as internationally renowned healthcare research and provision. However, these assets are not reflected in the health and wellbeing outcomes of the local population which are amongst the worst in the country. There are also significant inequities within Manchester with a difference in life expectancy of over eight years between different parts of the city.

Manchester is at a pivotal point in its history. The recent devolution agreement with the Treasury to devolve powers to the Greater Manchester region was made in Autumn 2014. More recently a further devolution of the £6bn NHS resource to Greater Manchester from NHS England was agreed. This presents a massive opportunity to remodel and transform our health and social care system and close the inequity between the assets of the City and the health and wellbeing outcomes of its population.

Manchester's health and social care leaders have made a joint commitment to put the people and place of Manchester first and to work through any barriers of organisational interest and policy constraints rather than let them stand in the way of progress. The leadership of the Health and Wellbeing Board is fundamental to this principle being at the heart of delivery of this plan.

1.1. Manchester’s strategic direction

Manchester's leaders seek to continue the economic growth of the city and the city region, to connect that growth to Manchester people through increased employment opportunities and to deliver effective public services at the most local level. The Health and Wellbeing Strategy sets out the specific priorities which describe how health and wellbeing can be improved within Manchester in the context of this broader strategy.

As part of this the **Living longer, living better** programme was established to set out the vision to transform community based health and care services. The programme’s vision is to radically transform the City’s community based care system by establishing a ‘One Team’ approach with the focus upon ‘place’ rather than organisation and person rather than disease. The aims of the programme are to:-

- Improve outcomes for the people of Manchester
- Improve service standards
- Support self reliance of people in the City
- Ensure sustainable finances for the health and care system.

1.2. One Team - Place Based Care

The Living longer, living better vision can only be achieved by bringing together all community based services to provide proactive joined up care as 'One Team', working toward shared outcome goals. Care should be joined up and with a focus upon proactive care in the community which keeps people well enough not to need reactive and expensive hospital or long term social care.

Rather than by disease or organisation care should be organised around the place in which people live. Teams should be structured around geographical areas and work as part of that

local community tailoring the care to local needs and linking to and strengthening local assets, including local organisations, volunteering and unpaid carers.

Adopting a One Team approach is a shift to a new way of working. It will require a cultural shift in how different professions work together but also a fundamental change in the more practical aspects of work such as estates and IT systems.

A key aspect of the model is the empowerment of provider organisations and frontline staff to collaborate and innovate to provide the best care possible for the local population. For this reason this specification is not unduly prescriptive. It describes the scope, the broad service model and the outcomes measures commissioners wish to see. It leaves the detailed design and implementation of delivery to partnerships of providers and stakeholders to deliver.

1.3. Broader context

There are a number of other key programmes in place in Manchester e.g. Mental Health Improvement Programme, Macmillan Cancer Improvement Programme. These programmes will reframe their work in the context of One Team and Place Based Care. This is now the framework for all developments in out of hospital care. This doesn't change the aims and objectives of these programmes but rather it sets a framework within which they progress.

Whilst this document focuses upon community based services, it is important that they are considered within a wider system. The city model for community based services will need to interface with all secondary and inpatient physical and mental health services in order to ensure flows between acute and community care are effective across the system. This will mean the three hospitals will need to develop some form of common way of working across the city in order to work effectively with the community system.

1.4. Integrated commissioning

There are a number of organisations commissioning health and care in Manchester. In order to achieve this model commissioners need to align their commissioning strategies so there is one clear ask of providers. Manchester City Council and the three Manchester CCGs have jointly developed this specification and will work closely in the commissioning activities to support this model becoming a reality.

SECTION TWO: 2020 COMMISSIONER SPECIFICATION

2. Introduction

This specification outlines the One Team – Place Based Care model. It describes what commissioners want to see implemented in terms of service model and outcome goals.

The specification has been developed drawing from desk research, learning from Manchester's integrated care work to date, stakeholder engagement and input from experts within health and social care organisations in the city. There are supporting documents available to supplement this document listed in appendix one.

This is a specification aimed at all providers who deliver care based in the community. For the purposes of this document ‘community based care’ refers to all care delivered in the community including primary, physical and mental healthcare as well as social care.

Commissioners invite our providers and other stakeholders to come together to design and implement this specification.

2.1. Outcomes

2.1.1. Aims of the outcomes framework

The outcome framework for One Team has a number of purposes. These are described below:-

- A common set of outcome measures which are shared across the health and care system which are a framework for continuous improvement.
- A common and shared set of goals for all professionals/services delivered in the community.
- A means by which teams can target improvement work and tailor care delivery to the specific needs of their local population.
- A common set of goals which the team can communicate with local groups, public, patients and carers to achieve together as a wider team.
- A means by which commissioners can measure outcomes, monitor contracts and plan future strategies.

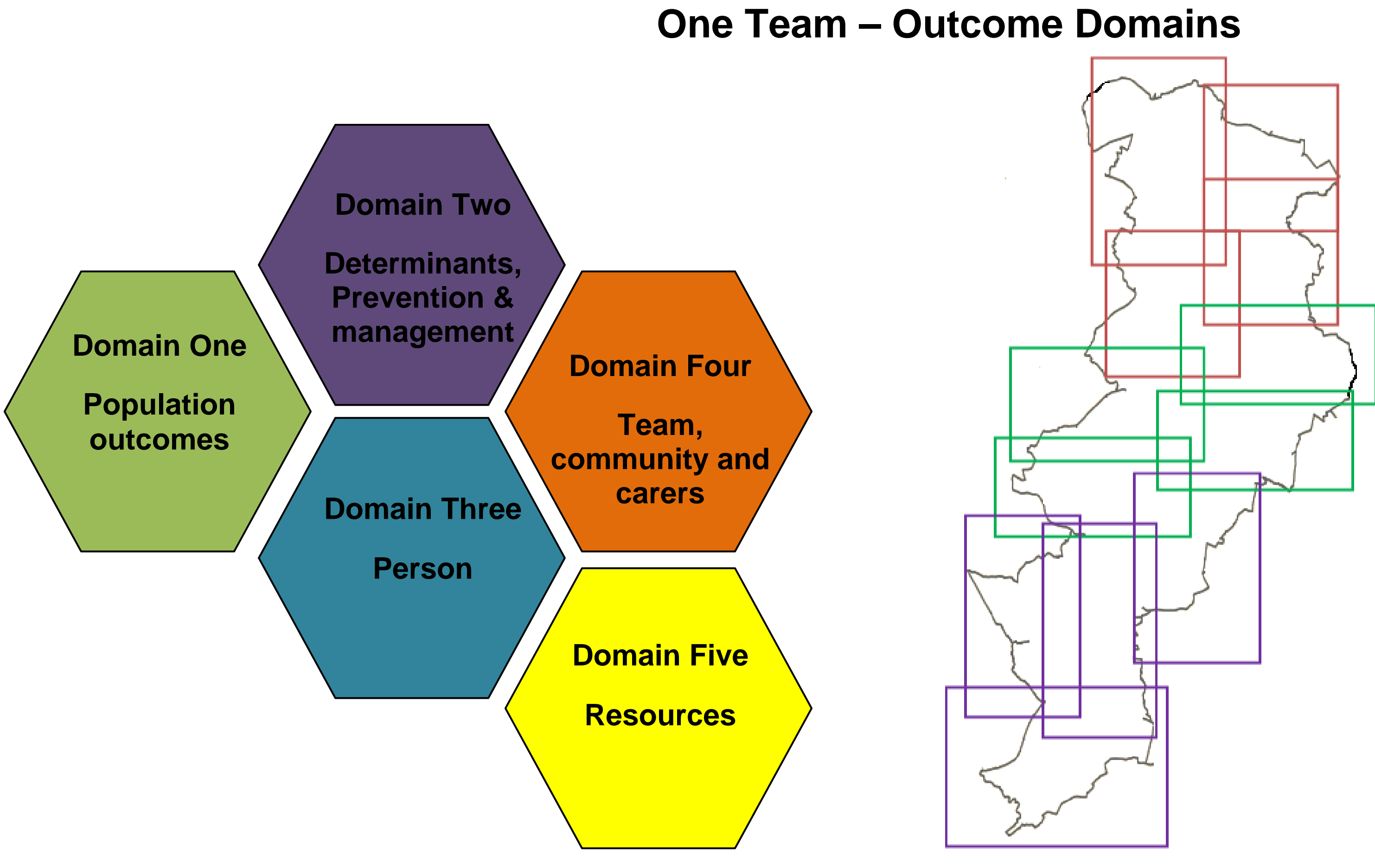
The outcomes framework will not replace existing performance requirements such as emergency access or infection control. Its aim is to establish improvement goals and describe what success would be in terms of health outcomes for the population.

2.1.2. Outcome goals for One Team

The outcomes framework has five domains which are described below. A further document outlining the detail of these and the specific metrics will be produced. The domains look at different themes but are also outcome goals from different perspectives. Some focus upon the specific impact we wish to see for the population and some measure the method by which teams work in order to achieve them. Results, where possible, will be reported at a population level, by team and protected characteristic group and index of deprivation group. This is with an aim to support improvement and reduce inequity. We will seek to close the equity gap between team areas, protected group and by index of multiple deprivation grouping.

These outcomes clearly described the aims of One Team. The practical application of these outcomes measures will needed to be tested in terms of feasibility of measurement and specific metrics in terms of availability of data and frequency of update e.g. life expectancy .

One Team – Outcome Domains



Domain One – population health

Rationale

Aim
This domain is focused upon health outcomes for the Manchester population. These are ultimate goals of the teams. The aim is that these are clear and quantifiable measures of success and act as a means of targeting improvement areas on a continuing basis.

Link to One Team
More effective working within teams will identify and coordinate delivery of the best interventions in a timely way drawing upon all the skills and resources of the health and care system will improve these indicators.

Outcomes

Best start in life
- Breast feeding rates 6-8 weeks
- Hospital emergency admissions <5 yrs
- Uptake of immunisations and vaccinations

Life expectancy and reduced health inequalities
- Life expectancy at birth
- Healthy life expectancy
- Premature mortality
- Reduce health inequalities

Dying in place of choice
- % of deaths in place of choice
- Carer reported feedback on the end of life phase

Quality of life
- Self assessed quality of life e.g. EQ5D
- Non elective hospital bed days & readmission rate
- Service users feeling in control of their daily lives
- Mental Wellbeing e.g. Warwick Edinburgh Mental Wellbeing scale.
- Carer reported quality of life
- Prevalence of long terms conditions

Quality and safety of services
- Readmission <30 days
- Safeguarding
- Safety incidents (specific to multidisciplinary working)
  - Breach of confidentiality
  - Communication failure
  - Inadequate hand over of care
  - Care plan not followed
  - Avoidable emergency admission

Domain two – Determinants of health, prevention and management of ill health

Rationale

Purpose of domain:
This domain focuses upon the determinants of health and wellbeing. Provision of healthcare contributes less than 20% to population health. It is important that these determinants are part of the City's plan for improved health and wellbeing.

Link to One Team
More effective connections within teams will identify more opportunities to promote good health, identify ill health where it occurs and support the delivery of effective interventions as soon as possible. Teams being well connected in their communities will bring new opportunities for health promotion, increasing screening and diagnosis rates. Local connections can be developed with housing, employment etc. as other key determinants of population health.

Outcomes

People have healthy lifestyles e.g.
- Diet - 5 portions per day & BMI between 18&25
- Exercise - 30 minutes 5 days per week (150 mins per week subject to medical advice)
- Smoking (overall rates)
- Alcohol - drinking less than 21 units (men) 14 units (women) per week
- Social interaction
- Mental wellbeing

The wider determinants of health are influenced
- School readiness
- Educational attainment at 16
- Increase in employment in working age population (including those with health condition).
- Reduction in housing and environmental risk factors
- Regular income sufficient to live a decent quality of life
- Social and community connection
- Children living in poverty

Ill health and need for social care is identified effectively
- % uptake of screening programmes
- Identification of chronic disease (physical and mental health)
- Optimal treatment of chronic disease (physical and mental) and social care issues
- Identifying people at risk of ill health e.g. exacerbation of a chronic condition
- Identification of need for social care or support e,g. frailty, loss of spouse, partner, carer

Domain Three – Person

Rationale

Purpose of domain:

The purpose of the domain is to ensure that teams work in a way which offers good experience to its users and that services are delivered in such a way that they are most effective. The domain includes a set of co-produced statements from the perspective of the public. This domain also states areas where people can contribute to their local health and care system. Achieving these statements is considered to be the role of the team and the public together.

Link to One Team

Where local health and care services operate in a way which works best for the local population they will have a more positive impact upon their health. If teams work with the local population to make sure services fit the needs of the local population they will be more effective.

Outcomes

One Team will mean... ***"our services are co-produced"***

- We are able to participate in the planning and design of services
- We are supported and invested in as patients, services users and carers to advocate for common needs
- We are able to build on existing collaborative relationships and good practice
- We want equal participation to tackle the causes of inequalities
- We want sustainable involvement of individuals and communities

One Team will mean... ***"We have good access to care"***

- We are able to access services when we need them
- We receive our care and treatment in a co-ordinated and timely way
- We are seen in an environment that is accessible, clean and free from harm
- We are able to use public transport which is accessible
- We can find the venue and we are able to park easily

One Team will mean.. ***"Our services are inclusive"***

- We are not discriminated against
- We wanted services to reflect our needs
- We are able to share our knowledge, skills and expertise as a result of living with our conditions

One Team will mean.. ***"We receive high quality care"***

- We are treated as individuals with our needs, values and preferences respected
- We are treated with dignity and respect
- We are treated in a safe environment
- We have access to the emotional and practical support we need
- We are able to involve our loved ones/carers in decisions about us
- We have a choice about our care

One Team will mean... ***" I am enabled to promote my own health and wellbeing "***

- We are an active partner in our care
- We have an active role, when we would like to, in making decisions about our care, treatment and support
- We are supported to look after ourselves day-to-day
- We have access to information, which is presented in a way that is right for us, that help us understand what is happening and lets us make decisions about our care

One Team will mean... ***" Communication is meaningful"***

- We have a voice in decisions made about us, as do those who care for us.
- We are asked how we would like to be communicated with
- We want communication to be delivered with care and compassion
- We are given information to make informed decisions about our care
- We have the opportunity and time to ask questions

One Team will mean… ***" I can improve my own health and wellbeing by…."***

- Eating well including eating five portions of fruit/vegetables per day
- Exercising at least 30 minutes five times per week (subject to medical advice)
- Have a healthy BMI of between 18 and 25
- Not smoking
- Drink less than 21 units (men) 14 units (women) of alcohol per week
- Use services responsibly
  - Attend or cancel appointments
  - Attend routine screening or health checks if invited
  - Use urgent services responsibly www.choosewellmanchester.org.uk/
- Following my agreed care plan

Domain Four – Team, community and carers

Rationale

Purpose of domain:
The purpose of this domain is to ensure that teams work as effectively as possible. This is a mix of designing in features to the teams, giving teams the tools to do the job, ensuring the wellbeing of the team and that they are closely connected to the community in which they work. For the purpose of this domain the team includes unpaid carers as well as paid front line staff.

Link to One Team
If teams work effectively, are motivated, have the resources to support them, are kept well themselves and have strong links with community organisations and other assets then they will be in strongest position to develop an effective health and care offer to the local population.

Outcomes

Teams work effectively

- Assessment using IMTA (integrated team monitoring & assessment tool (or similar)
- Seamless working within the 12:3:1 model
- Carers' experience of care giving
- Teamwork (NHS staff survey Q4 teamwork)
- Quality of care provided (NHS staff survey Q9)

Teams work well within their communities

- High levels of support from local residents for people with long-term conditions - this could take the form of formal volunteering, informal support with community locations, neighbour support or peer group support.
- A number of team members involved in joint projects with organisations in their patch (to ensure that the ethos of working with local organisations is embedded throughout the team rather than solely with management or a specialised community worker) - Joint Projects can take a wide range of forms including community action, co-production, provision of health and welfare services and cultural and arts activities.
- A significant level of contribution to the local economy - could take a number of forms including employing people living in the local area, free use of premises, assisting local organisations to bid for money, buying services from local businesses, staff and maximisation of benefit entitlements.

Teams have what they need to work effectively

Teams will be asked to determine what they need to be able to work effectively and self assess periodically against these. –

- Leadership – within team and within system
- Autonomy

The team has good wellbeing

- Staff Wellbeing
  - Sickness/absence rate
  - Staff wellbeing (NHS Staff survey Q14)
  - Recommend as a place to work (NHS Staff survey Q12)
  - Satisfaction in care delivery (NHS survey Q9)
  - Vaccination rates
- Carer wellbeing measures
  - Carer wellbeing (subset of domain one, two & four)
  - Carer survey
  - Self reporting wellbeing
    - Incidents of carer breakdown
    - Feeling supported to care
    - Professional support to support quality of life
    - Vaccination rates

Domain Five – Resources

Rationale

Purpose of domain:
The purpose of this domain is to ensure that the health and care system is sustainable in the short, medium and long term. It is also to ensure that growth in community based care is resource effectively and that the shift from hospital budgets is realised.

Link to one team
Well coordinated proactive care delivered in the community will reduce demand upon expensive and reactive care in hospital or long term nursing and residential care. This will enable the resource shift and sustainable finances going forward.

Outcomes

A balanced and rebalanced health and social care budget

- Financial balance of commissioner and provider budgets
- No greater than 'medium' risk financial position for future years
- % of health & care budget spent on community based care
- % of health & care budget spent on anticipatory care
- Investment in self care and community capacity building
- Prevention spend/activity in line with stepped care model

Good value for money

- Medicine waste
- Did not attend appointment (DNA) rates
- Duplicated activities
- Duplicated infrastructure
- Productivity benchmarking indicators
- Compliance with NICE guidelines and interventions with a strong evidence base.

Resource shift out of hospital

- Financial balance of commissioner and provider budgets

		Shift to England average	Shift to NW SHA average	Agreed target Shift	Annual growth anticipated (14/15 to 18/19)	TOTAL 5 year growth anticipated (14/15 to 18/19)	Net five year growth / (shift)
CMFT	A&E	22%	-2%	-10%	2.00%	10.00%	0%
	EL	9%	15%	-8%	2.50%	12.50%	5%
	DC	9%	15%	-8%	2.50%	12.50%	5%
	NEL	35%	20%	-20%	2.00%	10.00%	-10%
	OP	17%	15%	-16%	0.70%	3.50%	-13%
UHSM	A&E	22%	-2%	-10%	2.40%	12.00%	2%
	EL	9%	15%	-8%	2.00%	10.00%	2%
					2.00%		
	DC	9%	15%	-8%		10.00%	2%
	NEL	35%	20%	-20%	2.00%	10.00%	-10%
	OP	17%	15%	-16%	1.50%	7.50%	-9%
PAHT	A&E	22%	-2%	-10%	0.61%	3.05%	-7%
	EL	9%	15%	-8%	0.71%	3.55%	-4%
	DC	9%	15%	-8%	0.76%	3.80%	-4%
	NEL	35%	20%	-20%	0.73%	3.65%	-16%
	OP	17%	15%	-16%	0.74%	3.70%	-12%

- Achievement of shift targets (nursing and residential care)
- At least 50% of resource saved from secondary care is invested in out of hospital care.

2.2. Service Design

2.2.1. Key features

One Team
Front line staff, with carers, should see themselves as 'One Team' working for their population. Professional identity or employing organisation should not act as a barrier to integrated working enabling coordination of care and improved outcomes. Closer connection between physical and mental health, and health care and social care services.

Place - 12:3:1
Teams' focus should be on the 'place' they serve. Place is defined geographically and the intention is to have local teams within the City**(12)**. Some aspects of the model may not be practically delivered at such a local level. For example, where services require infrastructure or where specialist staff are needed. For this reason some services will be established at the CCG level **(3)** and some at the City level **(1).** Conversely some may be dependent upon being well connected to local communities which may warrant higher cost operational delivery but improved impact.

Services should be provided at the most local level possible. Where they are delivered on a larger scale they should be established in way which works into local team arrangements.

A stepped care model
Service delivery should follow a stepped care model such as shown in figure one Care should be delivered at the lowest level possible and care should increase in intensity where necessary and decrease when possible.

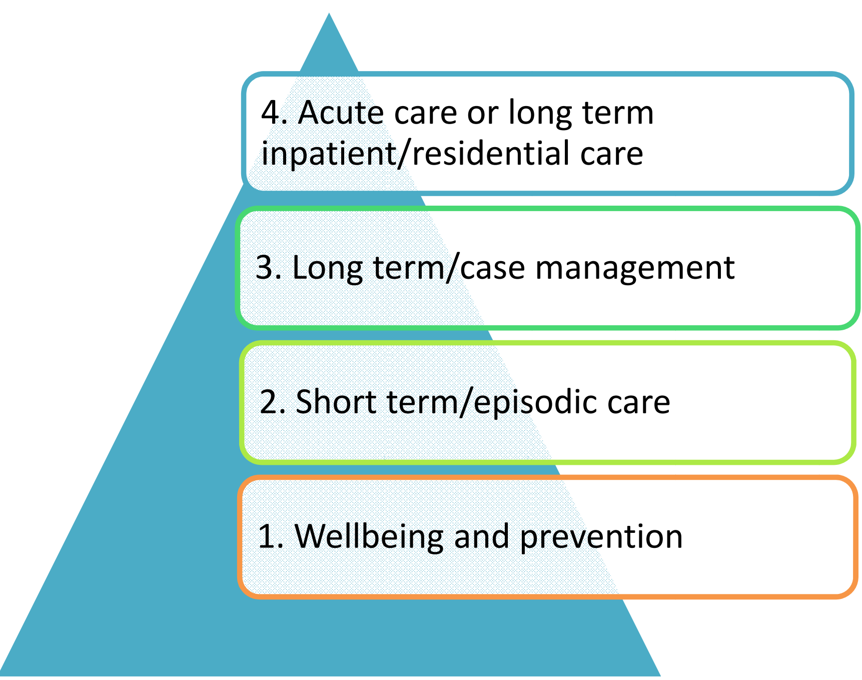


Figure one – Stepped care model

The scope of One Team is the first three levels of this stepped care model. However, the clear interface with secondary mental and physical health services needs to be in place to ensure a seamless service and that level four is time limited where feasible.

Flexibility
Not all care needs a multidisciplinary approach. However, it is important that when this is required the relevant skills can be brought together easily to ensure effective care planning and care delivery. Hitherto services have been designed very specifically to target cohorts of patients. The shift should now be to a flexible multidisciplinary model whereby skills specific to the individual can be drawn from the teams easily.

Shared outcome goals
Teams will work to a common set of outcome goals for the local population. Overall outcome goals will be set by commissioners (see section 2.1) who will agree the very specific metrics and key performance indicators with providers each year as part of the annual contracting process.

Equity
It is important that the service offer and outcomes citizens receive are equitable as far as possible. The One Team model cannot close the outcome equity gap by itself and closing existing gaps in equity will take many years. However, teams should understand and take positive actions to close those gaps and evaluation should identify and measure those as well as possible. The characteristics by which we would seek to ensure equity of offer and outcome are.

Protected characteristics for Equality, Diversity and Human Rights

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex (gender)
- Sexual orientation

Whilst deprivation is not defined as a protected characteristic it is important that there is not an inequity in service delivery.

This specification and provider proposals will be subject to a full equality impact assessment.

Coherent city model
It is important that teams can tailor their services to the needs of their communities and innovation is promoted at the front line. However, there needs to be clear city level design parameters which allow the 12:3:1 system to work effectively. In addition the three hospital services will need to create a common interface with the new community sector.

Scope
One Team is not a new team but rather an alignment of existing community based care services. This will include physical as well as mental health; social as well as healthcare; primary care as well as community services; and statutory and non statutory services. One Team should drive out duplication between services to ensure a simplified and efficient system. It should also drive out gaps created by eligibility criteria, transitions and gaps in the offer.

Growth
We wish to see community based health and social care grow in terms of its offer to the public and for this to be matched by an increase in resources. This resource can only be directed to the community by a shift from other downstream services. Growth in the community offer should be through growing capacity and skills within the teams rather than adding new discrete services.

Anticipatory care
Growth in community based care is not about shifting the same care to a new setting. It is focused upon proactive and well coordinated care which keeps people well enough not to need secondary care or long term care packages. If care is more proactive in its nature and there are less gaps between professionals and organisations there will be a reduction in expensive reactive care. This is key to both improving health outcomes and managing public sector finances in a sustainable way. It is the win:win situation we are seeking.

Preventative care
Teams will support primary and secondary prevention, primary prevention focused upon protecting health people from developing disease or ill health in the first place, secondary prevention ensures that after disease or ill health is diagnosed it is identified early and optimally treated to halt or slow the progress of disease.

Self Care
Team members will enable residents to maximize self care so that they are active in the management of their own health and wellbeing. Staff will have the skills to enable self care including using techniques such as motivational interviewing to determine patient priorities and wishes. They will also support residents with self care information and other resources. Self care will form a key component of individual care planning and care plans. Increasing people's ability and motivation to self care will lead to better prevention of lifestyle related conditions, better long term condition management, better medication and treatment compliance and reduced waste and urgent care activity.

Unpaid carers
There are approximately 60,000 unpaid carers in the city, approximately a quarter of whom are children. This compares with circa 40,000 paid front line staff. Adopting a workforce planning approach to unpaid carers to allow them to give the most effective care and ensuring that their own wellbeing is supported should be a core part of the model.

Innovation
Teams need to be given the skills and the permission to innovate within city level design parameters. Care services will need to be tailored to local communities and so front line staff are best place to adapt care to the needs of their population. Use of new technologies to support care and care giving is a significantly untapped resource. Innovation will be supported by evaluation as part of a learning approach. A structured means of sharing learning both positive and negative will be put in place between teams.

Connection
Teams should form connections in order to be able to understand the wider offer to people within their local communities. There are key areas where teams can work with other parts of the public sector such as housing, employment and Neighborhood Delivery Teams which support people in a more holistic way. Community, voluntary and faith sectors are key players and have a much stronger role to play as part of the wider team. Teams should establish capacity to identify and work with local communities contributing to and benefiting from local assets and different approaches to delivery through co-production. Knowledge should also be built around the transient population within an area which the health and care system also has a responsibility toward.

Culture
This model relies upon people more than anything else. It is key that teams have ownership of, and commitment to, the vision. A cultural shift to new ways of working as well as practical support in making teams work effectively is needed as part of organisational development strategies.

Workforce planning
The more practical aspects of the workforce need to be considered. The skill mix of the health and care system will change as well as all staff needing to develop new ways of working. Some generic skills and developing the 'trusted assessor' role might be incorporated into training. Leadership roles should be built into team design to ensure effective coordination and focus upon achieving improvement goals. Where implementation has been successful elsewhere investment has been made in workforce training, coaching, co-design and action learning approaches. In defining the workforce this should include unpaid carers and volunteers.

Identity
As part of team development the new system should include teams having an identity as a team but also which can be recognised by the public as their local health and care team. Subdivisions within teams should be kept to a minimum to aid common identity and ensure flexibility of people to apply skills to people's needs.

Estates
Whilst not all staff and services need to be co-located it is important to recognise the benefits of this. It is key to forming team working arrangements, to delivering joined up care where a person sees two professionals at the same time and also for community care to have a presence and identity within the community. This could be based upon a hub and spoke model with at least one identifiable building where services are delivered for the community i.e. at least, but not limited to, 12 health and care centres in the city. All other premises should be connected to this hub and have access to the facility as would local voluntary sector groups. A joint ownership model for estates and IT across partners in the system would allow flexible and joined up working but would also drive cost efficiencies through reduced duplication of infrastructure. Estates planning should look beyond health and social care buildings as part of the 'One Public Estate' strategy.

IT & Digital approaches to care
A key enabler to the team working arrangements is to optimise sharing of clinical records either through single clinical records or shared access to different records. In addition, modernisation of working arrangements for mobile working and use of new technologies should be incorporated into this arrangement. IT infrastructure should be part of a joint asset strategy with estates and IT application linked to innovation approaches within teams.

Digital approaches are likely to play an increasing role in enabling people to find out about their condition, to monitor and treat themselves, to exchange information with others.

2.2.2. Configuration

2.2.2.1. Population served & boundaries

This model applies to the full population of Manchester. For CCGs this is determined by GP registration plus residents of Manchester who are not registered with a GP. CCGs are not responsible for commissioning of healthcare for residents of Manchester who are registered with a GP in another CCG. For social care this is determined by residency in the City of Manchester. It is important to note that ward boundaries are artificial lines on a map and do not influence how people use or access services but they do create administrative boundaries which can act as a barrier to effective service delivery. Arrangements will need to be in place to aid these cross boundary issues. A full report has been completed which gives supporting analysis to the issues raised below. Depending upon their local circumstances different teams will have different challenges relating to the issues outlined below.

2.2.2.2. Boundary analysis

Macro level

Patient flows have an impact at the City, system and local team level. Based on GP registers (January 2015) there are just under 55k people registered with a Manchester GP but resident in another local authority. This is most prominent in North Manchester (30k people 15%); Central Manchester (15k people 6%), South Manchester (10k people 6%). There are also 25k people living within Manchester but registered with a GP in another CCG area.

CCG	GP Registered population					Resident registered population				
	Total	Resident in area		Resident outside		Total	Registered in area		Registered outside	
		No.	%	No.	%		No.	%	No.	%
North Manchester	198,023	168,055	84.9%	29,968	15.1%	177,553	168,055	94.7%	9,498	5.3%
Central Mancheste	220,987	207,008	93.7%	13,979	6.3%	213,943	207,008	96.8%	6,935	3.2%
South Manchester	170,804	160,515	94.0%	10,289	6.0%	169,481	160,515	94.7%	8,966	5.3%
Manchester	589,814	535,578	90.8%	54,236	9.2%	560,977	535,578	95.5%	25,399	4.5%
Source: Health and Social Care Information Centre (HSCIC), October 2014.										

Figure two – city cross boundary flows

The age distribution of these is important to note as it will impact more significantly on multidisciplinary working e.g. boundary clashes might be an issue in 0-5yrs and over 65yes but less so in adults of working age. The chart below shows South Manchester CCG registered and resident populations which are broadly representative of patterns across the city. Further analysis of this issue is required in order to better understand the implications for the delivery of place based care in different parts of the city.

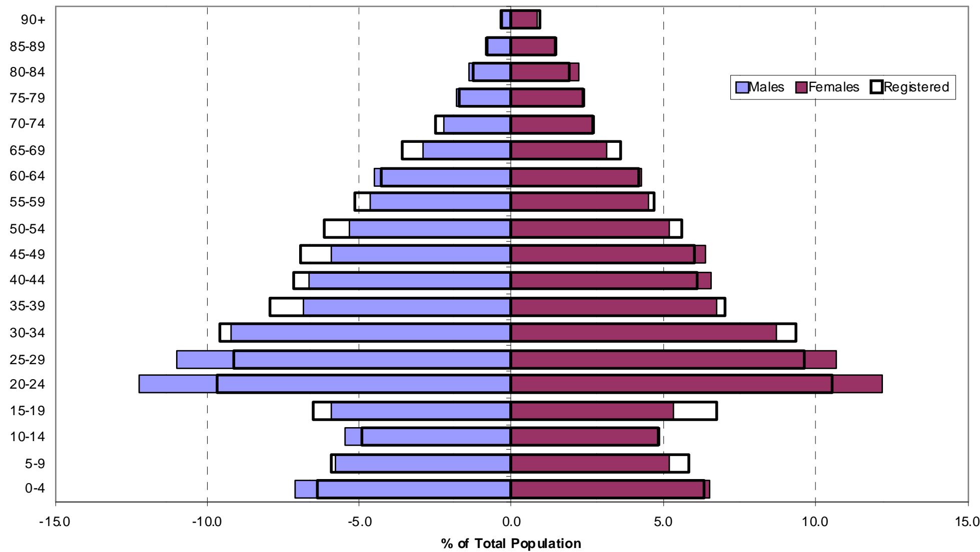


Figure three – South Manchester cross boundary by age

Micro level

The cross boundary flows are more noticeable at a local team level. Whilst there will be less administrative issues e.g responsibilities split across local authority boundaries there is challenge to determine how people should be assigned to the team. Teams, therefore, will be defined by the GP registration of the individual. This means the connection to communities may have overlaps between teams and this will be a challenge to address.

Of the local teams, as proposed (see 2.2.2.2), the proportion of patients registered with a GP practice within their locality of residence ranges from 80% (Wythenshawe) to 44% (Withington and Fallowfield). In the design process assessment of tweaks to configuration of teams might be beneficial.

Five out of the proposed twelve teams have significant numbers of patients living outside Manchester. These may require working arrangements to be established between local authorities and CCGs.

Hospital catchment

A further dynamic is the catchment area of hospitals. Patient flows are influenced more by patient choice of provider and the geographical catchment area surrounding a hospital. CCG and LA boundaries are relatively artificial boundaries which don't influence the choices patients or ambulance crews make. Teams will need good working relationships with hospitals and in some areas hospital catchment areas will overlap. This has significance both in admission and discharge management but also that the vertically integrated community and acute services' relevant populations do not match. The maps below show the overlapping catchment of hospitals for Manchester registered patients for each hospital. It shows significant overlap demonstrating the case for some degree of commonality of the hospital interface within the three trusts and the ability for community services provided by one hospital and their 'place' team having strong working arrangements with the acute services of another. It is important to note that most children's community services are provided by CMFT and most adult services are provided by the respective trusts in North, Central and South Manchester.

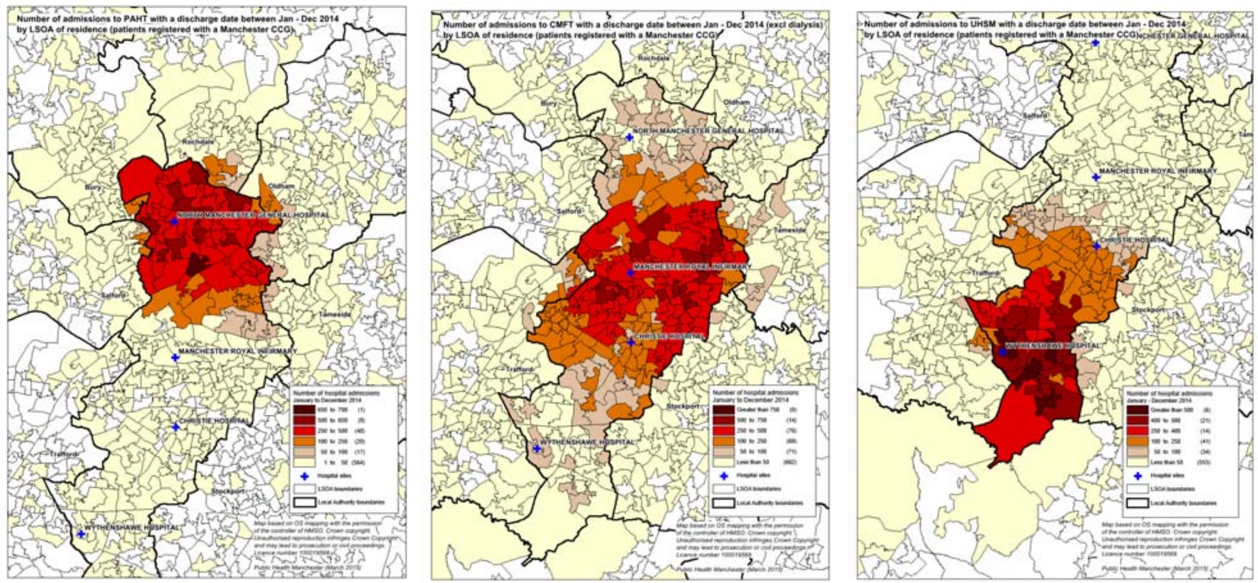


Figure four – hospital cross boundary flows

2.2.2.3. 12:3:1 Model for teams

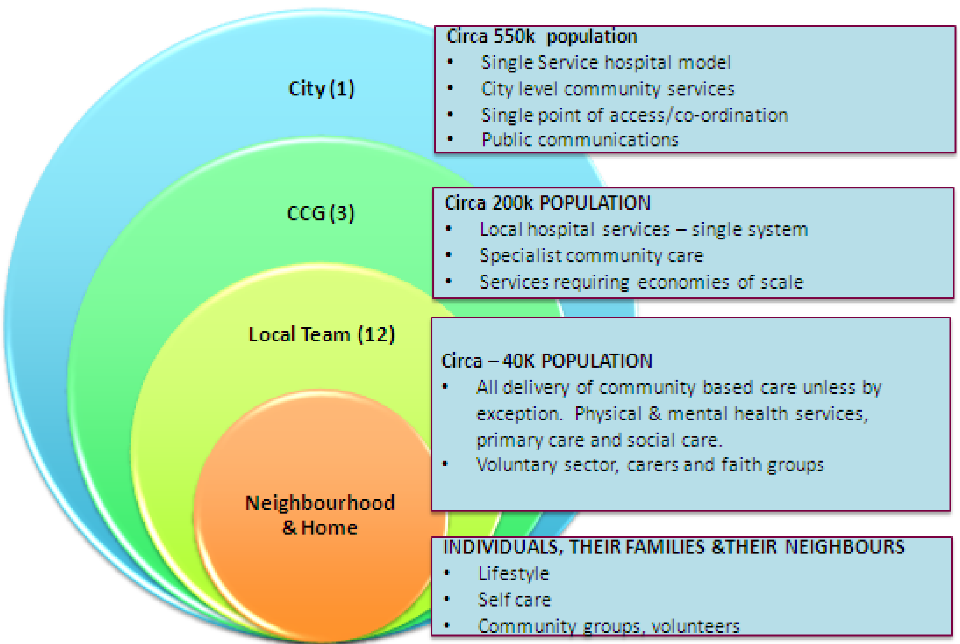


Figure five – Place model 12:3:1

Place will work at a number of levels. The default basis for teams is within 12 local teams (organised around aggregations of electoral wards) The majority of community based care will be delivered within a local team. Where services cannot be practically delivered on that basis then they will work on a locality (CCG area) or a City basis.

Local Teams will be based upon groups of wards:-

North area

- Cheetham and Crumpsal
- Higher Blackley, Harpurhey and Charlestown
- Miles Platting, Newton Heath, Moston and City Centre
- Ancoats, Clayton and Bradford

Central area

- Ardwick and Longsight
- Chorlton, Whalley Range and Fallowfield
- Gorton (North and South) and Levenshulme
- Moss Side, Hulme and Rusholme

South area

- Wythenshawe (Baguley, Sharston Woodhouse Park)
- Wythenshawe (Brooklands) and Northenden
- Fallowfield (Old Moat) and Withington
- Didsbury (west and east), Burnage and Chorlton (Chorlton Park)

2.2.2.4. Scope and phasing of implementation

Implementation will focus in phases. Each phase will actively manage the implementation of the One Team approach. Those services which are in subsequent phases should start to evolve to work with the emerging teams and develop working relationships at this point. However, it is only practical to start with a manageable number of services.

2.2.2.4.1. Phase One - commencing April '15

- **Primary medical services**

Primary medical services are fundamental to the model. General Practice is often the first point of contact into health and social care services. They conduct the largest number of patient contacts, they are the primary coordinator of care and they have a strong presence within local communities. Practices already have working relationships on the basis of the team areas described in section 2.2.2.2. and have experience in much of the integrated care service developments to date. Practices will continue to work in their current contractual arrangements for their core contract.

- **Community health services - adult services**

Community health services are provided by the three hospitals within Manchester. They have been fundamental in the development of new service models in the community over the last few years. In the first instance adult services will be in scope with a view to including remaining services in the next phases. See note regarding integration with adult social care.

- **Adult social care**

One of the key benefits of work to date has been drawing together health and social care. As part of council plans there is a proposal to integrate adult social care with community health services and this should run in parallel to the implementation of the One Team model. Further detail regarding the nature of this integration will affect how this is undertaken.

- **Community mental health services**

From experience of multidisciplinary working the input of mental health services into care planning has been valuable. It is important that mental health is a core part of the emerging model of community based care and the assumption that all community based care operates in this way is relevant also to mental health services. There is significant overlap between physical and mental health. The implementation of One Team is linked to the Mental Health Improvement Programme and associated work. The mental health pathways, already specified by commissioners and, where based in the community, will be delivered within the One Team model. The mental health pathways use the step care model (shown in figure 1, page 13). Not all aspects of these pathways are appropriate for delivery in the community. Where they are they should be developed as part of the One Team model. Where this is not possible there should be effective transitions up and down the pathways.

Mental health pathway specifications are:-

Non psychotic pathways
1. Depression
2. Anxiety
3. Obsessive compulsive disorders
4. Common mental health problems with long term physical health problems
5. Post traumatic stress disorder and panic disorders
6. Eating disorders
7. Personality disorders

Psychotic pathways
8. First episode psychosis

9. Acute crises
10.Rehabilitation from psychotic illness
11. Severe mental health problems with substance misuse

Organic pathways

12. Dementia

Specialist liaison pathways

13. Maternal mental health
14. Community based forensic mental health services
15. Mental health services for people with a learning disability
16. Autism and ADHD in adults
17. Psychosexual services

The pathways are based upon NICE guidelines and, therefore, have an evidence based approach to management of these diagnoses. There are instances where there are social circumstances or physical health co-morbidities which mean it is desirable to adapt pathways to best meet the needs of the individual. The mental health specification allow this deviation from guidance in appropriate circumstances.

- **Urgent Care First Response (UCFR)**

Urgent Care First Response (UCFR) is a significant piece of redesign work in progress. This fits within the One Team model but cuts across a number of providers. UCFR seeks to bring all services which provide an initial response to an urgent, or perceived urgent, need into one coherent system with reduced gaps and overlaps in service and easy means of directing the patient to the right part of the urgent care system in a timely way.

2.2.2.4.2. Phase Two - Onwards

Whilst there is a focus upon the phase one in terms of formal implementation other parts of the health and care system needn't remain static. By necessity some services will need to adapt around the emerging teams. All parts of the community system can start to adapt, form linkages and become involved. The teams should start to form connections with local community groups.

Implementation will follow in a number of phases. The assumption remains that all care devliered out of hospital should be within scope unless it is considered to be outside.

The other commissioned services identified as part of the One Team model are:-

- District General Hospital services – where they can be delivered in the community
- Ambulance services
- Primary Care Services (pharmacy, dental, optometry, out of hours)
- Children's community services [nb early years model]
- Children's social care [nb early years model]
- Community health services commissioned by MCC e.g. health visiting, school nursing.
- Learning disabilities services
- Public health services and preventative interventions
- Voluntary sector commissioned services
- Commissioning of some packages of care, including delegation of commissioning budgets e.g. aids and adaptations, care packages and potentially prescribing.

2.2.2.4.3. Indirectly in scope

It is important that teams connect well with services outside the scope of the team and with non statutory organisations but the following areas e.g..:-

- District General Hospital based services which are not practical to deliver in a community setting need an effective interface which has a degree of constancy across the city.
- Specialist services
- Police and fire services
- Local housing providers
- Local job centres
- Non social care commissioned services by MCC

This is not an exhaustive list and as teams become embedded in communities more opportunities can be identified by teams.

SECTION THREE – NEXT STEPS FOR REQUIRED FOR IMPLEMENTATION

3.0 Next steps for implementation

3.1 High level plan

The aim is that section two forms the basis for the relevant providers, with stakeholders as appropriate, to develop design and implementation plans which will start to put this model into place. Timelines for implementation of phase one will be agreed as part of the design work. However, integration of adult social care with community services has a pre-existing deadline of March 2016. This should form the assumed timescale for all of phase one but this needs to be subject to feasibility assessment.

This invitation to providers will form three parts. To put in place the design and implementation for:-

- Enhanced self care and established social movement for change
- Implementation of the One Team and Place Based Care approach as defined within this document.
- A plan for how providers will organise themselves and work with others effectively. This will describe how they will start to work differently, practically and culturally, to deliver care differently as part of a One Team approach.

3.2 Approach to implementation

3.2.1 Provider led approach

Our aim is that providers of services within Manchester will collaborate to reshape existing services to evolve into this model. The high level specification in section two will form the parameters for this and commissioners seek to take a hands off approach to the design and implementation phase. There is an expectation that implementation will be achieved through existing resources, with any available investment prioritised toward supporting this.

The commissioning role in implementation is focused upon three key areas.

1. To define the health and wellbeing outcomes required and to describe the broad service model which is the purpose of this document.
2. To put in place the environment for change to happen by working with others to develop working relationships, systems for collaborative working and development of the infrastructure for community based care.
3. To ensure standards are met and improvements are made.

3.2.2 Commissioner relationship

The key to the model is to pass flexibility and responsibility to providers and onward to front line staff to design, implement and innovate to ensure the best service model is put into place. However, an ongoing dialogue to ensure alignment strategically will be key and assurance that implementation is taking place within the parameters of the design in section 2.0. In taking on this role providers, collectively, will have a responsibility for achieving the outcome goals agreed with commissioners. There will be a clear contracting and performance arrangements in place to ensure this. Some parts

of the health and social care system have not yet developed the working arrangements to operate within this devolved approach. In these cases commissioners will develop the more detailed specification in partnership with providers and seek to develop those working relationships over time.

3.2.3 Taking a forward view

The One Team vision will be realised over a number of years. Each year detailed plans will be required for implementation with changes needed relating to workforce, IT, Estates and resource distribution. These more tactical decisions will need to be in the context of the longer term vision so subsequent phases of implementation do not make the tactical decisions redundant.

It is important that service areas implemented in phase two onwards are not seen as lesser partners within this vision. Engagement and involvement in the establishment of the teams should start as part of phase one.

3.2.4 Learning approach

The shift towards the One Team approach is complex in terms of organisational and cultural change. It is important to ensure that learning takes place throughout and beyond the implementation phases. As each phase of implementation takes place the learning is passed to the next. Improvement approach such as PDSA cycles will be needed.

3.2.5 Enabling work

As part of the LLLB programme there are a number of enabling workstreams. These are all citywide but will have local implementation in some cases. Some of these workstreams have a commissioning focus and some a provider focus. However, all will have good involvement across the system and some, such as estates and IT, will have a significant contribution from each. Enabling workstreams have commenced but will develop a brief from this specification for the short and longer term implementation. These works streams are:-

Provider led

- Design and implementation of commissioning specification
- Estates
- Information management and technology
- Workforce and organisational development including recruitment and retention strategy.
- Communications and engagement (implementation)
- Co-production

Commissioner led

- 2020 Commissioning Design
- Self care
- Commissioning and contracting
- Finance
- Performance and evaluation

3.2.6 Developing an evaluation and performance framework

There needs to be a good balance between performance management and improvement focus driven from performance and evaluation. This will require mature working arrangements within and between organisations.

The outcomes outlined in section two will be developed into a performance framework which will set baselines, target improvements and track metrics over time. This should have a focus upon improvement and learning rather than being a punitive tool. However, there is a discipline required

from this in that the need to grow community based care is only affordable on the basis of making the health improvements as set out in the outcomes frameworks.

3.2.7 Commissioning, contracting and finance

Development
The commissioning role, as described in section 3.2.1 will require two key actions. Firstly organisational and personal development to shift to a new way of working. A further shift from transactional to collaborative working arrangements and collective leadership approaches.

Integrated commissioning
The One Team model is a specification from the three Manchester CCGs and Manchester City Council. In order to commission this effectively the four commissioners are starting to work more as One Team and are developing stronger integration between teams.

Contract models
In the LLLB strategic outline case an assessment of contracting models was undertaken and subsequently an alliance contract has been implemented. The contracting model(s) for One Team will be assessed when the design and implementation plans are complete. The funding and contracting model should be the best enabler of achieving the desired outcomes.

Provider working arrangements
As the partnership approach to service delivery scales up commissioners will look to see the strength of relationships between providers within the system. There will need to be further increase in the strength and depth of governance and mutual accountability between providers of commissioned services.

Funding
Given the current financial circumstances the health and social care system needs to implement this change within the existing package of resource. Financial sustainability relies upon a significant improvement in people's health thus reducing demand for expensive reactive care. Finance packs will be developed to support the design and implementation phase

The market approach
Commissioners wish to support current providers within the city to come together to redesign how they deliver care within this model. We see it as a reshaping of existing services and a strengthening of integration and coordination. Therefore, there is no imperative to enter a procurement approach at this macro level. Where there are gaps in the building blocks of the new system or issues of quality we will enter into procurement exercises as has been undertaken to date.

The ask of providers
Commissioners are inviting providers, with others, to develop the following:-

1. A design and implementation plan for delivery of this specification
2. A plan for how they will organise and develop themselves to deliver this specification

3.3 Timeline for next steps

- Living longer, living better strategy developed and supported by Health and Wellbeing Board ✓
- One Team and Place Based Care agreed as the vision for delivery of the LLLB Specification ✓
- Draft One Team commissioning specification developed for engagement with stakeholders ✓
- Stakeholder Engagement ✓
- Final Commissioning specification submitted to Health and Wellbeing Board for approval (JUNE '15) ✓
- Provider response to Health and Wellbeing Board for support (JULY '15)
- First phase implementation MAR '16

  Full implementation MAR '20

Thank you to all the people who have supported the development of this specification.

Questions or comments relating to this specification can be sent to edward.dyson@nhs.net

#OneTeamMCr

Appendix One - Supporting documents

Report on best practice evidence and learning on Health and Social Care Integration Teams (Dr Shirley Woods-Gallagher & Anna Thorogood – MCC 2015

Statements of what people want from One Team LLLB Co-Production Group & survey monkey results

Carers report – David Williams

One Team – Community Outcomes - Nigel Rose MACC 2015

One Team Vision – CWLG

LLLB Strategy - CWLG

Health and Wellbeing Strategy – HWB

Stakeholder events outputs

Cross Boundary Flows Report - Neil Bendel

Place Based Profiles – Bendel/Hayler

Co-produced I/We statements and public survey results - LLLB Co-Production Group

Mental Health pathway specifications

Early Years new delivery model

Finance packs

Summary report from March 31st Stakeholder Event

Raw data March 31st Stakeholder Event

“person outcomes” survey monkey results