One Team Prevention Programme

This paper describes the proposed approach to prevention for One Team and Manchester's LCO. More broadly it describes the activities required to enable One Team to take a community-centred, asset based approach to delivering care, and promoting health and wellbeing for residents of the 12 One Team neighbourhoods. This approach is fundamental in transforming the care we deliver to one that is person-centred and enables people to live as independent a life as possible. This will reduce demand on health and care services, whilst promoting community resilience and improving health outcomes. It will be an exemplar for "Our Manchester" , the emerging framework of asset based approaches for the City.

Community assets include the skills and connections of local residents, local associations and groups, arts and cultural assets, resources of organisations, local stories, and physical resources such as buildings, parks and, libraries.

The proposed programme will provide the foundation for scaling up successful local initiatives. It will support creativity and innovation at neighbourhood level, within a defined framework of objectives, for improving population health.

The proposal has been developed with contributions from a wide range of stakeholders including providers from primary care and the voluntary, community and social enterprise sector (VCSE), Manchester's Clinical Commissioning Groups (CCGs) and Manchester City Council.

1 Vision

Our vision for the prevention programme is to help keep Manchester's residents as healthy as possible, and narrow the gap between the healthiest and the least healthy in the City. Our focus is on **people with long-term needs**; this includes people with long-term conditions as well as people whose social circumstances place them at high risk of developing long-term conditions or becoming frequent users health and care services in the future.

What will be different for Manchester's residents?

'The Public's Health – Person, Partner, Place' is the first priority for transformation in Manchester's Locality Plan. When this approach is embedded in One Team we would expect;

- People with long term needs will be more able to take an active role in staying healthy and managing their health (self care)
- There will be a higher level of use of community resources and assets for addressing the social determinants and improving health and wellbeing
- The capacity or number of appropriate community resources for supporting people with long term needs will increase where required
- Communities will be more involved in developing local services to meet their needs.

By mobilising and strengthening the assets of people and communities to improve their health and wellbeing, and tackling the social root causes of ill health; we will reduce demand for more reactive services from people with long-term needs.

2 What is the proposal?

Over the next 5 years, primary care services across Manchester will be transformed, and will actively shape and lead the development of 12 neighbourhood teams.

Neighbourhood health and social care services, including GPs, community health services, social care workers, dentistry, pharmacy and optometry will work together to improve the health and wellbeing of their populations. At the heart of this new approach, will be a strong relationship between these neighbourhood teams and the local community; including residents, voluntary and community groups, and organisations which work either within the locality or citywide (for example leisure services, libraries, cultural organisations, parks and others). Together they will proactively promote improvements to wellbeing, prevention of ill-health and reduction in health inequalities for their residents.

The prevention programme will provide an infrastructure that enables sustainable, coherent and effective community based approaches to prevention across the city. Neighbourhoods will be supported to deliver the objectives of the programme with flexibility and creativity to allow for determination of local needs and solutions by local people, in keeping with the place based approach.

The **5 objectives** of the programme will be for neighbourhood teams to;

1) Support residents in **strengthening the social determinants of health** such as employment and skills, finance, housing and social connectedness
2) Support the adoption of **healthy lifestyle choices** across the life course such as physical activity, nutrition, smoking cessation and emotional wellbeing
3) Improve the quality of life, health outcomes and life expectancy of people with long-term conditions by **identifying long-term conditions early ("finding the missing 1000s")**, and facilitating a **proactive approach to management of long-term conditions**
4) **Optimise the health of people with long term conditions**, both by enhancing standards of clinical care and **supporting the mental health and social needs** of people with these conditions
5) Use asset-based, personalised and holistic approaches to **enable self care.**

The infrastructure for enabling this work includes new roles (community link workers and neighbourhood health coordinators), funding to maximise use of community assets, a social prescribing hub (community links for health) and a time-limited transformation team to deliver the large scale change required. Although a number of the new roles should be permanent, they will also "mainstream" the new ways of working through peer support and knowledge sharing with traditional health and social care practitioners.

Life course approach

The prevention programme will prioritise activities across the life course as described in the table below. This life course approach will contribute to GM's population health outcomes described in the "Taking Charge" strategy.

Start Well	Live Well	Age Well
Support for pregnant registered residents to improve lifestyle behaviours in pregnancy that will improve child health outcomes Support for families with young children to improve nutrition and behaviours that improve oral health Improve proactive management for children with asthma Support for adolescents with mild to moderate mental health concerns and promotion of adolescent mental wellbeing	Identification and support of registered residents who are out of work to move towards employment Identification and holistic support of registered residents with lifestyle risk factors for LTCs -smoking, harmful drinking, obesity, low mood Identification and holistic proactive management of people with undiagnosed hypertension, chronic kidney disease (CKD), diabetes, COPD, atrial fibrillation and lung cancer) Support for patients with physical or mental long-term conditions to strengthen the assets (work/housing/social connections) that help improve health and wellbeing	Support activities that reduce risk of falls from mid-life Support for registered older residents who are socially isolated and lonely to improve social connections/reduce loneliness

3 Why is it required?

The health of people living in Manchester remains among the worst in England, with a high number of preventable deaths. Manchester currently has the second lowest life expectancy at birth for men and the lowest life expectancy at birth for women.

The largest contributors to the gap in life expectancy between Manchester and England are circulatory diseases, cancers and respiratory diseases. Circulatory, respiratory diseases and cancers are also among the high spend areas. All the lifestyle behaviours that lead to these poor health outcomes are highly prevalent in Manchester; adults in the city have higher rates of obesity and alcohol misuse, and smoke more than the average levels for England. There is also considerable variation within Manchester, with some wards and areas and particular groups in the population, showing considerably higher levels of ill health and deprivation than others. It has been estimated that health inequalities in Manchester give rise to at least £300-320m in economic losses and £53m in costs to the NHS per year (based on losses estimated for England in the Marmot Review and extrapolated to the Manchester population). These estimates will be greater if the relative deprivation and existing levels of inequality are taken in to account.

The North West Mental Wellbeing Survey for 2012/13 shows that low mental wellbeing among people living in Manchester is associated with employment status, poor general health and a higher prevalence of diagnosed medical conditions. Long term conditions are responsible for a large proportion of GP consultations, result in high expenditure on unplanned care and are projected to rise with the ageing population.

Identifying people with long-term conditions as early as possible and ensuring that they receive optimal treatment will improve the quality of life for this population and limit the costs of these conditions to the system. In the mid to long-term, however, the greatest impact will be seen by preventing these conditions from occurring in the first place. This can be achieved by changing the relevant lifestyles and behaviours and, more significantly, by addressing the social determinants of health and intervening in the early years of life. This can only be achieved by working more effectively with the groups, organisations and services best placed to have an impact on these areas. The prevention programme we develop should allow people to access the support that best meets their needs, to improve their health and promote wellbeing.

4 How will it work?

4.1 Neighbourhood health and wellbeing development (c.£1m)

The aim of this it to enable the leadership teams of the 12 Neighbourhoods to develop and implement neighbourhood plans that (i) make the most of local assets to target local needs and (ii) are co-produced with local community groups and residents. This will facilitate locally tailored approaches to achieving the 5 objectives of the programme that are appropriate for that community. We would expect this to include projects that promote physical and creative activity and address social isolation, place-based activities to identify people will long-term conditions who have not been diagnosed. GP registration would also need to be facilitated, particularly among vulnerable groups, in order to maximise the population health impact of the programme. This work will build on existing engagement mechanisms e.g. Age Friendly Neighbourhoods, and on existing assessments of health needs and asset mapping.

The development work will be achieved by placing a neighbourhood health coordinator in each of the 12 neighbourhood teams, and giving each team access to a neighbourhood health fund to invest in the new ways of working.

Neighbourhood health coordinators will develop an understanding of local assets and factors that have an impact on health and wellbeing. They will be part of the neighbourhood leadership team and facilitate connections between this team and local residents, statutory and VCSE organisations.

Their knowledge of determinants and assets will be informed by needs assessments, local research, consultation and engagement. They will pull together knowledge and intelligence that has been gathered by statutory organisations and non-statutory organisations including soft intelligence and asset mapping that has been conducted by various groups and organisations.

The coordinator will support neighbourhood teams to work with communities to develop local action plans, implement small-scale projects and feed into city-wide plans. They will also be able to use the knowledge, skills and resources of health and care practitioners who are part of One Team to maintain, enhance and support the development of other community assets for health.

Specifically, the neighbourhood health coordinators will support neighbourhood leadership teams in;

- Understanding population based health approaches, asset-based care management and community asset development (how to approach and work with communities)
- Expertise and support in carrying out analysis, mapping, consultation and engagement
- Creating, developing and maintaining connections with a wide range of stakeholders
- Coordinating training for frontline public sector workers in having conversations of about health (supporting the Making Every Contact Count programme)

A Neighbourhood health fund of £30k per neighbourhood will allow neighbourhood leadership teams to apply for investment in locally developed projects. The criteria for the fund will necessitate partnership with local community groups and organizations, and focus on the aims and objectives of the prevention programme. Grants of up to 5 years duration will be allocated to projects that meet the criteria and potential to contribute the transformation required. This fund is to "start-up" the community centred, asset-based way of working for One Team. Successful projects will be supported to access long-term investment for example through the citywide voluntary sector grants being developed for "Our Manchester."

4.2 Community Links for Health (c.£3.5m)

A coherent citywide social prescribing model will be developed to give people who access health and care services, a link to social and non-medical support within the community. One clear referral system or single point of access will allow One Team health and care practitioners (starting with GPs) to connect people with various sources of support that address the social determinants of health. Embedding this model will enable the transformation to an asset-based approach to health, and similar approaches that have been tested in the city to be delivered at scale.

Community Links for Health (CLFH) aims to connect residents of Manchester with a range of social and community sources of support to enable them to improve their health. This will be targeted at those individuals with an element of risk which could lead to adverse health outcomes at a later date. It will also enable holistic care for people in more acute risk cohorts, by addressing the social factors that affect their physical and mental health and quality of life.

CLFH will provide an infrastructure to facilitate the link between professionals working in neighbourhoods across Manchester and the individuals who require support. This will be delivered by professionals referring individuals into the city-wide CLFH hub who will then assess how best to meet their needs.

It is anticipated that these referrals may come from primary care professionals, social workers and other community-based health and care practitioners in each of the One Team neighbourhoods. Other options such as referrals from A&E could be explored by the LCO and neighbourhood teams.

The CLFH model comprises two elements.

(i) **CLFH hub -** a small city-wide hub of health coaches, specialist health coaches and some admin and management support. This hub will handle all incoming referrals from professionals in the first instance with a specialist health coach carrying out all initial assessments to determine the level of need, communication needs and type of support required for each individual. The majority of initial contacts with the hub will be telephone-based. The initial assessment carried out by a specialist health coach in the hub is key as it will determine the best course of action for that individual. Following the assessment, the individual will either; be dealt with over the phone with the case closed off at that point; receive a return call from the most appropriate professional (Hub Specialist coach / Hub non-Specialist coach / neighbourhood community link worker); meeting/home visit

arranged with the most appropriate professional (Hub Specialist / neighbourhood community link worker); onward referral to specialist external service. The hub will also provide specific support for people who are out of work to get into volunteering, training and employment. It will also include low intensity support for mild mental health disorders (level 2 IAPT)

(ii) **Community Link Workers (CLW**) will be based 'on the ground' at a neighbourhood level. There will be a team of CLWs in each neighbourhood with the size of this team depending on the need in that area, determined by the public health mosaic modelling. The CLWs will develop an in-depth knowledge and understanding of the various social sources of support and community assets available in a local area. They will be well connected to all of the local groups and organisations that work within the locality which can promote health and wellbeing - including voluntary and community groups, libraries, parks, cultural organisations and leisure services. We would expect them to be recruited from the area in which they are be based, and where possible reflect the demographics and cultures of the community.

Their role will also be to contact people referred through the CLFH process and assess the types of groups, activities and community assets which may best meet their needs. They will then link people up with the relevant community assets and sources of support for them. This may be simply informing them about an organisation or group in the local area but may also involve more intensive support and 'hand-holding' to enable the individual to attend or benefit from this.

A key skill for the CLWs will be relationship building both with the residents they are dealing with and also with the other neighbourhood level health and social care staff working in that area. The hub will be able to refer individuals to the CLWs where appropriate to offer one-to-one support, with approximately 50% of the CLWs acting as one-to-one support workers and the other 50% having a stronger focus on information gathering on community assets and working with the health and social care professionals in that area. In this way the knowledge and approach of the CLWs will be mainstreamed and enable the transformation required to an asset-based approach to care for neighbourhood teams. It is anticipated that some of the links between the CLWs and primary care will be determined by the individual neighbourhood teams. Where there are existing CLW roles within neighbourhoods, these can work alongside CLFH as "partners", and be included as part of the structure. These staff ("partner community link workers") may be employed by different agencies/voluntary organisations.

A core set of skills will be essential for both the health coaches in the hub and the CLWs, to ensure a person centred approach to meeting individual needs. The assessments carried out will be strength-based and focus on what individuals want to achieve and what an improvement in their health or circumstances would look like to them. This may be more downstream issues such as wanting to improve their management of a long term condition such as diabetes, improve their diet or stop smoking. It may also be more upstream, concerning some of the wider determinants of health such as debt or housing concerns they may have, which could ultimately affect their health. It is essential that the workers are recruited and trained by a provider with experience and expertise in this way of working to maximise early impacts of the model.

Each individual receiving support via CLFH will have ongoing contact with the same key worker for the duration of the support they receive. This may be from one of the health coaches within the hub or a CLW in the neighbourhoods. After receiving support, there will be a follow-up period for each individual of 3 months for lower level of need and 12 months for the higher level of need (as determined by the initial assessment and ongoing contact). It will also be the responsibility of the key workers to collect outcome data from the support the individuals have received and particularly outcomes from any external services that they have accessed.

4.3 Citywide transformation team (c.£1.2m)

This is a short-tem investment in a team and programme of work to develop and deliver the transformation required over the next 5 years. The focus of the work will include;

- Implementation of our strategic approach to enabling self care
- Development and implementation of approaches to address health literacy
- Development of accessible information resources for neighbourhood teams to use with people they are supporting
- Development of the prevention and care model requirements to address mental health parity – how do we equally improve mental health of people with long term needs, and how do improve physical health of people with mental health conditions? This will be done in partnership with mental health commissioners and providers and inform the mental health investment proposition.
- Volunteering development for one to one support – supporting the development of timebanks at neighbourhood level
- Enhancing community resources - maintaining the quality and effectiveness of VCSE organisations in supporting physical and mental long-term conditions.
- Neighbourhood planning and co-production - support and advocacy for co-production and links with citywide VCSE organisations and communities of interest
- Pathway optimisation for long-term conditions – development and implementation of a citywide, all systems population health approach to reduce spend on LTCs that result in the most unplanned activity and therefore cost. This would include supporting primary care integration and standards.
- Development of clinical analytics unit to enable a strategic approach to case finding and risk stratification using available data citywide
- Development of the information management and technology systems required to achieve the aspirations of the programme
- Technology enabled health – embedding the use of assisted technology by connection with GM and other programmes and implementing them in Manchester
- Ensuring access to education and training to enable the required behavioural and cultural change to deliver an asset based approach, enable self care and optimise the identification and care of people with long-term conditions

A smaller number of staff would need to remain in the long-term as part of any citywide or locality governance structure of the LCO in order to support the programme to continue. The management and administrative functions need to be considered as part of the overall LCO proposal.

5 Who is the programme for?

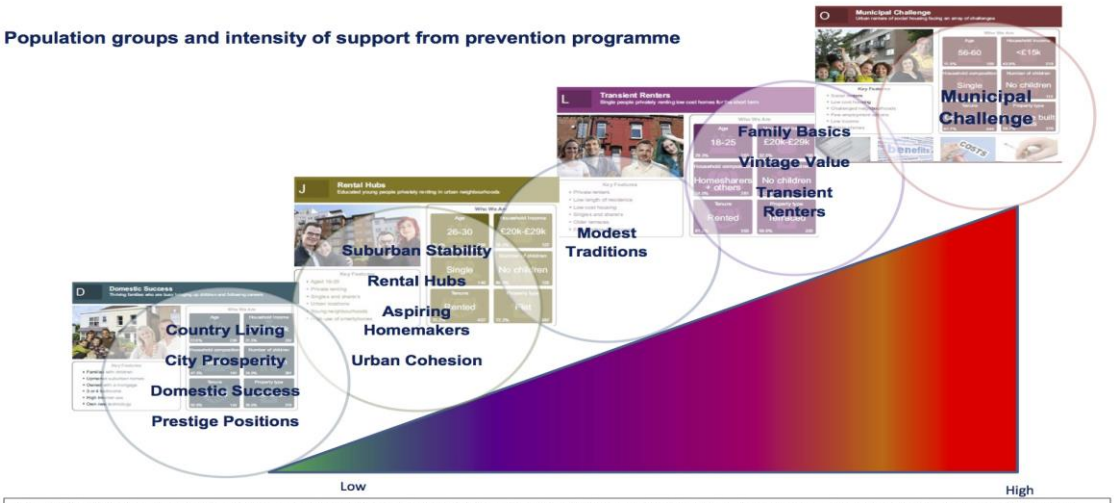
We know that the social conditions within which people live are linked to healthy lifestyle behaviours, and have an impact on their mental and physical health. There are many people in Manchester who are vulnerable to developing complex mental and physical health conditions, as a result of their life circumstances. This will ultimately result in a high level of need for health and social care services. Many of these people may not yet meet the criteria or thresholds that allow them to access current services based on social or medical risk. The aim of the programme is to support people before they can become classified as "high risk of emergency hospital admission", or "complex dependency" It would also aim to support people whose lifestyles do not yet require support from specialist prevention services such as weight management, specialist smoking cessation and alcohol and drug services.

The intensity of support given to individuals by the programme will increase with levels of need. These needs as defined by conventional risk modelling such as, "latent risk", "rising risk" and "acute risk" tend to based on a medical model. However, the level of need from a prevention perspective has to be defined by the root causes of preventable ill-health and health inequalities, which are primarily social.

The Mosaic Public Sector classification system (ExperianTM), groups populations in terms of their demographics, lifestyle, behaviours and location. 15 groups have been described based on a broad range of socio-demographic factors. We have analysed this data focussing on the health related factors that are most likely to be impacted by the prevention programme. Using this approach we can describe the level of support that different population groups might require from the programme, based on a combination of socio-demographic factors rather than the conventional medical "risk modelling" approach. This data can also means we can map the neighbourhoods in Manchester where the groups that need the most support live, and deliver the programme accordingly.

The bubbles in the diagram capture the Mosaic population groups that will require different levels of support from the programme. People who fall in two groups 4 and 5, represent the highest need based on social circumstances and are referred to as "**people with long-term needs**" for the purposes of the programme. Less intensive forms of support will be available for people at lower risk.

Population groups and intensity of support from prevention programme



Mosaic Public Sector classification by Experian™ provides and understanding of resident's demographics, lifestyle, behaviours and location which can be used to deliver appropriate public services and engage residents effectively. Using the health related factors that are most likely to be impacted by the prevention programme; we grouped the Mosaic population groups into levels support they might require from the programme. The nature of the Mosaic classification means that social factors are also taken account, producing cohorts based on a combination of factors, rather than a conventional medical "risk modelling" approach. The Mosaic graphics displayed are for the groups within each bubble, which have the largest number of people in Manchester. This data can also be used in mapping where the groups that will need the most support live.

Percentage of population in each group: Bubble 1 (Municipal Challenge) =6%, Bubble 2 (Family basics, Vintage value, transient renters) =40%, bubble 3(modest reality) =3%, bubble 4 (Suburban stability, rental hubs, aspiring homemakers, urban cohesion, senior security) = 45%, bubble 5(Country living, city prosperity, domestic success,

1	2	3	4	5
Country Living Well off owners in rural locations enjoying the benefits of country life **City Prosperity** High status city dwellers living in central locations and pursuing careers with high rewards (typical age 31-35) **Domestic Success** Thriving families who are busy bringing up children and following careers (typical age 41-45) **Prestige Positions** Established families in large detached homes living upmarket lifestyles (typical age 61-65)	**Suburban Stability** Mature suburban owners living settled lives in midrange housing (typical age 56-60) **Rental Hubs** Educated young people privately renting in urban neighbourhoods (typical age 26-30) **Aspiring Homemakers** Younger households settling down in housing priced within their means (typical age 31-35) **Urban Cohesion** Residents of settled urban communities with a strong sense of identity (typical age 56-60)	**Modest Traditions** Mature homeowners of value homes enjoying stable lifestyles (typical age 56-60)	**Family Basics** Families with limited resources who have to budget to make ends meet (typical age 31-35) **Vintage Value** Older people reliant on support to meet financial or practical needs (typical age 76-80) **Transient Renters** Single people privately renting low cost homes for the short term (typical age 18-25)	**Municipal Challenge** Urban renters of social housing facing an array of challenges (typical age 56-60)

5.1 Communities of identity, interest and experience

In the course of the local stakeholder engagement and contribution to this proposal, the need to ensure that access to the programme for specific groups has been highlighted. The programme will be subject to EIA however it is important that these groups continue to be engaged as neighbourhood specific activities are developed. These groups include;

- BME communities
- LGBT communities
- Disabled people
- People with severe and enduring mental illness (SMI)
- Homeless people

6 How will it support Greater Manchester's Objectives?

The GM plan, "Taking charge of our health and social care" aims to close the gap between GM and England by raising population health outcomes to those projected for England in 5 years' time. Manchester's contribution to meeting these targets is at least one third for most of the outcomes described. The prevention programme will prioritise objectives across the life course that will contribute to meeting these outcomes. A summary of how the One Team Prevention Programme and other public health programmes of work will contribute to the "Taking Charge" outcomes is shown on page 18.

7 What will the benefits be?

The expected outputs and benefits of the programme are detailed in the logic chain in the appendices. The matrix describes the benefits for each of the target population cohorts for the LCO/One Team. We would expect the programme to have an impact on a number of key drivers for the LCO/One Team including;

- Levels of "patient activation" – the knowledge, skills and confidence people have to manage their own health and health care (this is associated with adoption of healthy behaviours, better clinical outcomes, lower rates of hospitalisation and higher levels of patient satisfaction with services)
- Levels of GP activity where more appropriate support could be provided
- Number of A&E presentations and unplanned hospital admissions
- Spend on medicines and prescribing
- Avoidable contacts with health and care services
- Individual and community wellbeing and resilience

8 What are the Enablers?

8.1 The Voluntary, Community and Social Enterprise Sector

There has been active engagement with and involvement from the VCS as part of the development of this programme involving several organisations. One of the key areas for the asset-based approach is the use of VCSE organisations in the community to provide support to individuals who may have non-clinical needs. One of the main aims of this programme is to increase the linkages to such organisations and services and increase their usage but another key aspect of this is to support and enable those VCSE organisations to be able to manage this increased demand and have the appropriate knowledge, skills and resources to do that. There are elements of the programme such as health literacy approach, enhancing community support which specifically aim to provide this support.

8.2 Housing

Residents engaged through the programme will have a mixture of housing tenancies including owner occupiers, private rented and social rented. For those living in social rented housing, the registered housing providers already provide a number of services and run various schemes aimed at improving the health, wellbeing and welfare of their tenants. One example is the social prescribing scheme that Southway Housing Trust runs in the Old Moat area of Manchester which offers a range of services for older people living in a naturally occurring retirement community. Engaging with such existing schemes will be a key role of the Neighbourhood Health Development Coordinators. There is also potential for partnership approaches to provision of the CLFH model between housing and VCSE providers.

Registered providers may also have some services which they are able to offer to other tenants of Manchester City Council housing stock, or those who are privately renting or owner occupiers. For those individuals engaging with this programme who are privately renting or owner occupiers, other relevant services available such as Manchester City Council housing services, private landlord groups and affordable warmth campaigns/schemes will be engaged in order to link with the range of other assets available.

8.3 Cultural, arts, sport and leisure sectors

There is ongoing dialogue between cultural, libraries, sport/leisure, parks and health and wellbeing colleagues. We recognise that access to a varied cultural, leisure, recreational and library offer is vital to supporting wellbeing, active citizenship, new skills, social connections and community cohesion. Manchester has a portfolio of high quality, city wide and neighbourhood cultural, sport and leisure facilities, both with opportunities to volunteer, participate, create, spectate, relax and learn. These sectors provide facilities and programmes directly but also support voluntary sector, community groups and individuals to develop, deliver and apply for funding to initiate and sustain their own activities locally. The prevention programme will support professionals and residents to make the most of these opportunities by:

- Increasing awareness/knowledge resources about what's on offer / ways to engage
- Ensuring referrals are appropriate and that services, organisations or groups are able to manage increased demand and have the knowledge, skills and resources to respond to that
- Strengthening partnerships with, and support for voluntary and community organisations and residents to; facilitate engagement, inform activity, deliver their own and host others` activity, and attract funding for local activity
- Making better connections and pathways between neighbourhood and city centre opportunities.

8.4 Workforce

The three themes or areas of investment will all require new roles to be introduced to the system; neighbourhood health coordinators, community link workers and health coaches (CLFH hub workers) and the citywide transformation team. The LCO in partnership with the workforce transformation group will need to consider the best option for employment during the transitional period and in the long-term. Apart from the CLWs and coaches who would be employed by the provider(s) of the CLFH service, we would anticipate that the LCO would be employer for these workers if its organisational form allows this.

These will need to be supported by a comprehensive organisational development plan, an as such be included in the overall workforce and organisational development plans for the LCO.

Recruiting the right people with the right skills will be key, as well as ensuring that they have access to appropriate training and development. Values based recruitment can be particularly useful in these types of roles to ensure that staff attitudes and values are aligned with an asset based and person-centred ethos. We would also need to aim to recruit from a diverse pool of candidates.

Manchester has already developed a service specification for asset based person-centred care in partnership with HEE which will be developed and delivered over the coming months.

8.5 IMT

The IM&T Workstream Programme Manager has been made aware of the programme of work and the high level IM&T requirements as detailed below.

Information governance, data protection and consent will need to be discussed and addressed as these solutions are developed. The GM IMT workstream will also need to be engaged to utilise opportunities for solutions that are best developed at scale.

At present the main requirements for the One Team prevention programme would be;

- The infrastructure to access shared information about community resources and information to promote health and wellbeing: One Team health and care practitioners, community workers and residents need to be able to access good quality and up to date information about local community assets and other ways of promoting health and wellbeing.
- A strategic proactive approach to case finding (missing 1000s) using available data: providing identified/agreed practitioners within One Team with access to routine searches of primary and secondary care data in order to support early identification of long term conditions, risk stratification and proactive management.
- A patient held record: a solution that allows patients to have ownership (control of) and access to a record of their care from different providers utilising mobile technology. This is different to having access to the professionals' patient record which maybe in less accessible language and which the patient has less control of.

- Information sharing among primary care providers: a solution that allows primary care providers to share information about the patients/residents they have seen/consulted with.
- Information sharing between CLFH hub and rest of One Team: the CLFH hub will need to be able to contribute information to the summary care record and access information within the summary care record. Outcomes of CLFH activity (include signposting outcomes) need to be recorded and accessible to the LCO.
- Referral system: there needs to be a simple electronic, integrated referral to system for providers that use CLFH to refer people to the service. An example would be the use of Emis templates in primary medical care

IT resource will be required to complete the following and funding will be requested through the transformation fund proposition process to support this;

- Fully understand and translate "To Be" requirements
- Understand any reporting requirements
- Confirm the current position – "As Is"
- Map against any available options
- Identify gaps
- Present solution options both tactical and longer term
- Determine costs for both tactical and longer term solutions
- Dependencies on the delivery any other IT developments underway
- Timelines for delivery
- Present an implementation plan for programme approval.

8.6 Estates

In order to adequately accommodate teams and individual staff members within each of the programme elements, there will be a need in terms of estates capacity.

Due to the widespread re-location and integration of health teams into the community, the supply of suitable accommodation in Manchester for staff is increasingly limited. Much of the existing capacity within community assets such as medical practices, health centres and community organisation accommodation has been filled by Phase One of the One Team integration. Smaller staffing numbers (1-2 people per location) may be able to be accommodated at existing sites; however larger groups may present challenges given current capacity issues.

There is project management support for this via the Locality Plan programme office and Manchester City Council. The local decision making body regarding estates is the Manchester Strategic Estates Group (SEG) who can be engaged further regarding our requirements. It is important throughout the development and subsequent implementation of the programme that colleagues responsible for estates capacity are kept well informed of the requirements. It will be important to provide strategic estates planners with key

information such as the size of teams moving into a location and the dates they will need to be accommodated from in a timely manner.

Appendices (to follow) – summary of information to support CBA modeling:

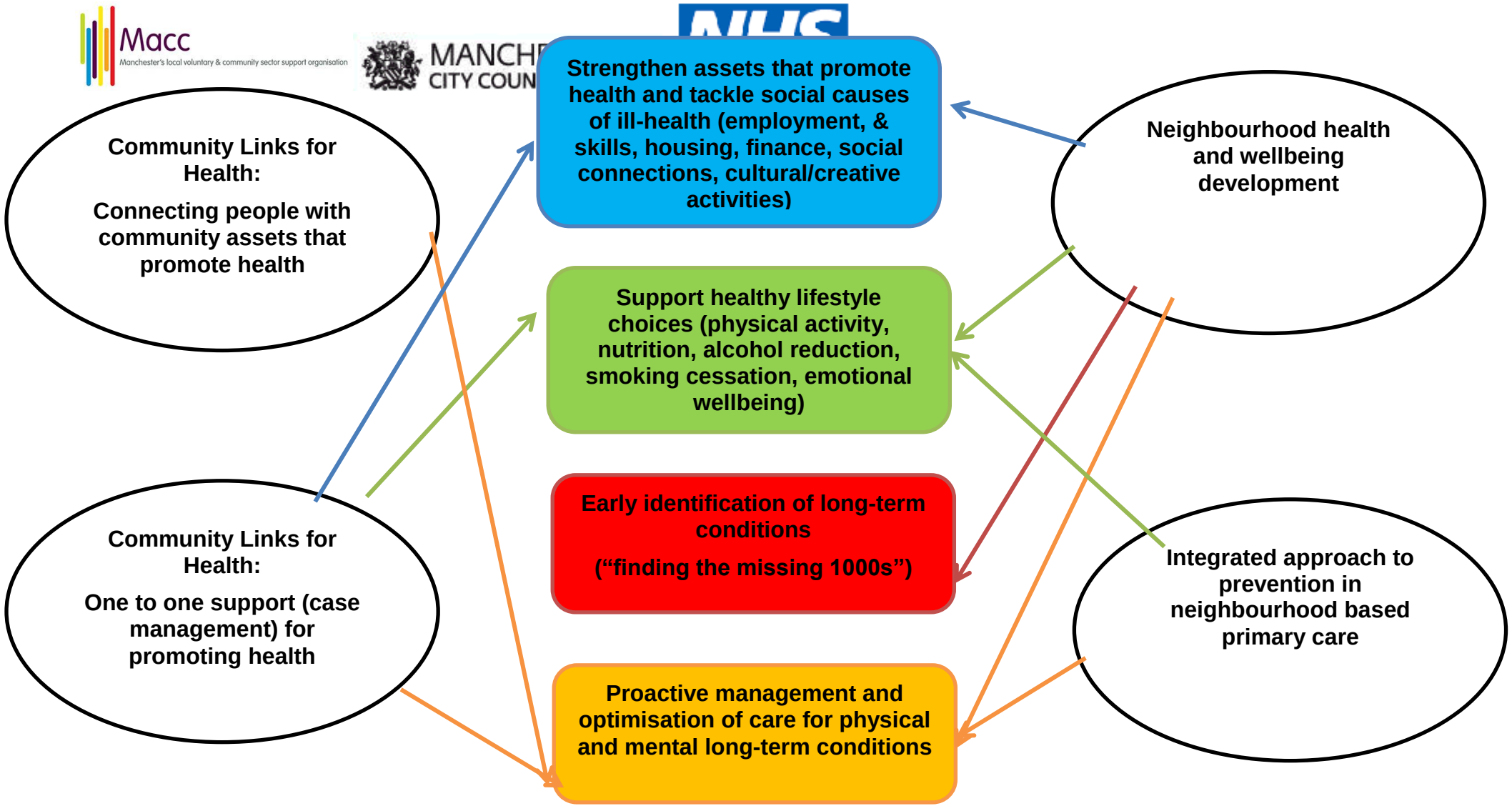
(i) Context: Population cohort definitions and data

(ii) Input: One Team Prevention Programme financial modelling summary

(iii) Outputs & outcomes: One Team Prevention Programme

(iv) Impact & timescales: One Team Prevention Programme logic chain matrix

(v) Summary: One Team Prevention Programme project scope documents


Macc
Manchester's local voluntary & community sector support organisation
MANCHE
CITY COUN
NHS
Community Links for Health:
Connecting people with community assets that promote health
Community Links for Health:
One to one support (case management) for promoting health
Strengthen assets that promote health and tackle social causes of ill-health (employment, & skills, housing, finance, social connections, cultural/creative activities)
Support healthy lifestyle choices (physical activity, nutrition, alcohol reduction, smoking cessation, emotional wellbeing)
Early identification of long-term conditions
("finding the missing 1000s")
Proactive management and optimisation of care for physical and mental long-term conditions
Neighbourhood health and wellbeing development
Integrated approach to prevention in neighbourhood based primary care
Enabling Self Care

GM Outcome	Manchester contribution	Manchester's Approach (see narrative for more detail)
START WELL		
More GM Children will reach a good level of development cognitively, socially and emotionally.	Improving levels of school readiness in Manchester to the projected England rate will result in 994 more children with a good level of development by 2021, an increase of 3% based on current levels (28% of the GM target of 3,520 more children, with a good level of development).	Early years delivery model Increasing physical activity in early years Children & Young People's Mental Health One Team Prevention Programme
Fewer GM babies will have a low birth weight resulting in better outcomes for the baby and less cost to the health system.	Reducing the number of low birth weight babies in Manchester to the projected England rate will result in 76 fewer very small babies (under 2500g) by 2021, a reduction of 5.5% based on current levels (28% of the GM target of 270 fewer very small babies).	Infant mortality programme Smoking Cessation System One Team prevention programme
LIVE WELL		
More GM families will be economically active and family incomes will increase.	Raising the number of parents in good work to the projected England average will result in 4,517 fewer Manchester children living in poverty by 2021, a reduction of 3% based on	Support via One Team Health and Work programme One Team prevention programme

	current levels (28% of the GM target of 16,000 fewer children living in poverty).	
Fewer people will die early from preventable Cardiovascular Disease (CVD).	Improving premature mortality from preventable CVD in Manchester to the projected England average will result in 174 fewer deaths by 2021, a reduction of 18% based on current levels (29% of GM target of 600 fewer deaths).	Support via One Team NHS Community Health checks Re-commissioned integrated drug and alcohol service (MIDAS) Smoking Cessation System Alcohol Strategy Weight Management service One Team Prevention Programme
Fewer people will die early from preventable Cancer.	Improving premature mortality from preventable Cancer in Manchester to the projected England average will result in 378 fewer deaths by 2021, a reduction of 20% based on current levels (29% of the GM target of 1,300 fewer deaths).	Support via One Team North Manchester lung screening for cancer pilot Smoking Cessation System Alcohol Strategy Macmillan Cancer Improvement Partnership (MCIP)

		One Team Prevention Programme
Fewer people will die early from preventable Respiratory Disease.	Improving premature mortality from preventable Respiratory Disease in Manchester to the projected England average will result in 168 fewer deaths by 2021, a reduction of 24% based on current levels (29% of the GM target of 580 fewer deaths).	Support via One Team Smoking Cessation System One Team Prevention Programme
AGE WELL		
More people will be supported to stay well and live at home for as long as possible,	Reducing the number of people over 65 admitted to hospital due to falls in Manchester to the projected England average will result in 653 fewer serious falls, a reduction of 11% based on current levels (24% of the GM target of 2,750 fewer serious falls).	Support via One Team Falls Prevention Alcohol Strategy One Team Prevention Programme Age Friendly Manchester – Neighbourhood action plans