Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 13 January 2016

Subject: One Team Commissioning Update

Report of: Lorraine Butcher, Joint Director Health & Social Care Integration
Claudette Elliott, Deputy Chief Officer, South Manchester CCG

Summary

This report seeks to provide the HWB with an update on the progress made by the One Team Commissioning Project Team in support of the first phase integration of health and social care services, scheduled to take place in 2016.

Recommendations

The Board is asked to note the contents of this report.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	
Educating, informing and involving the community in improving their own health and wellbeing	Yes – an explicit objective of the LLLB Programme.
Moving more health provision into the community	Yes – an explicit objective of the LLLB Programme.
Providing the best treatment we can to people in the right place at the right time	Yes – an explicit objective of the LLLB Programme.
Turning round the lives of troubled families	
Improving people's mental health and wellbeing	Yes – an explicit objective of the LLLB Programme.
Bringing people into employment and leading productive lives	
Enabling older people to keep well and live independently in their community	Yes – an explicit objective of the LLLB Programme.

Lead board member: Lorraine Butcher, Joint Director Health & Social Care Integration

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

The Blueprint for Living Longer Living Better was set out in '*Living Longer Living Better, An Integrated Care Blueprint for Manchester*', presented to the Health and Wellbeing Board in March 2013.

This was followed by the 'Living Longer Living Better Strategic Outline Case' presented to the Health and Wellbeing Board in June 2013, which described in more detail the three main areas or 'domains' of the city's plans for integrated care.

In November 2013, the Health and Wellbeing Board received a Strategic Business Case, which described in more detail the care models, the population groups and the financial case for change.

The LLLB Strategic Plan was presented to HWB in September 2014, and brings together the documents listed above.

The 2020 Commissioning Specification went to HWB in June 2015, followed by the Provider Response to the 2020 Commissioning Specification in July 2015.

The LLLB Programme also now sits in the context of the Manchester Locality Plan.

1. Commissioning of One Team

1.1 Work is on-going to secure the integration of frontline community services at a neighbourhood level, through a single contract and with a single contract holder from 2016.

1.2 The Commissioning timeline for One Team has been developed in collaboration with the Practitioner Design Team (PDT) to demonstrate the interdependencies between the practitioner and commissioning work streams. The commissioning 'products' that have been agreed to date include the:-

- One Team Outcome Framework,
- One Team Service Specification,
- One Team Contract.

1.3 The timeline indicates that the commissioners are reliant on the outputs of the PDT to complete the Service Specification, in terms of completion of the service models for the phase one workstreams. Commissioners have provided a framework (the Target Operating Models – TOM's) for practitioners to describe the service model and final drafts are expected at the end of January 2016 for Intermediate Care and Reablement and the end of March 2016 for Integrated Neighbourhood Teams. Timescales are currently subject to change and under the purview of the PDT scope and resource.

1.4 The latest version of the plan can be seen at Appendix 1.

2. Commissioning Project Team (CPT)

2.1 The CPT was established in June 2015 following a recommendation to the Executive Health and Wellbeing Board to put in place a Commissioning Project Team dedicated to developing the commissioning products necessary to support the implementation of the new service and contractual arrangements.

2.2 Following the response from the Manchester's providers the following are areas of focus for the CPT in order to ensure the necessary changes can be implemented:-

- Service specification(s) sufficient for incorporation into contracts;
- Assessment of contract form and new contracts developed/old contracts closed;
- Novation of relevant contracts and budgets into the single pooled budget;
- Assessment of the most suitable funding and pricing model;
- A performance framework, monitoring approach and means of holding to account;
- Alignment of related commissioned services i.e. those which are connected to the commissioning plan for 16/17 e.g. well-being service;
- Business cases developed where necessary and impact modelling undertaken for all changes;

- Working in partnership with providers to ensure system level redesign of estates, IMT, workforce is aligned.

2.3 The original membership comprised 12 representatives from across Health and MCC Commissioning. The current core membership can be seen below. Support from the LLLB Workforce, Communications and Engagement, Finance & Contracts and Business Intelligence workstreams is accessed as and when required.

2.4 The current core membership is:-

- Claudette Elliot, South Manchester CCG- SRO
- Julie Bloor, Joint Integration Lead
- James Williams, MCC Integration Lead
- Jane Thorpe, Citywide CCG Commissioning (Mental Health)
- Kaye Hadfield, North CCG Commissioning
- Stef Cain, Central CCG Commissioning
- Coral Higgins, Citywide CCG Commissioning (Cancer Care)
- Jayne Cooney, South CCG Commissioning
- Keeley Christine, MCC Commissioning
- Elaine Ridings, MCC Commissioning
- Barry Gillespie, Public Health Commissioning
- Abigail Prabhakar, Project Officer, MCC
- Alex Barke, Project Officer, MCC

3. Outline Service Specification

3.1 Work has now begun on developing the single One Team Services Specification. This will build on the high level commissioning intentions identified in the *One Team Specification 2020 Design* document. Examples of service specifications relating to existing neighbourhood teams and intermediate care and reablement have informed the draft specification.

3.2 A set of high level principles have been agreed with practitioners for inclusion in the specification. These principles (linked to the One Team Strategic aims) can be seen at Appendix 2.

3.3 A Task and Finish Group, chaired by the One Team SRO (Claudette Elliott) and comprising of practitioners and commissioners, now meets on a weekly basis to review progress on the TOM's and to develop the requirements of the Service Specification. In addition the Commissioners are in the process of establishing a small Editorial group which will oversee the content of the Specification document and the business case.

4. Outcomes Framework

4.1 In collaboration with practitioners an Outcomes Framework has been drafted for insertion into the Service Specification. This outcome framework focuses

on system wide change and transformation to achieve the overarching vision of shifting 20% hospital activity into the community by 2020.

4.2 The CPT have worked closely with the leads for the Locality Plan and the Health and Wellbeing Strategy to ensure the same outcome themes are included in the service specification and mirror the same methodology i.e. the LOGIC chain. Further revisions will be required after the document has been shared more widely, specifically with the Co-production and Self Care groups.

4.3 The draft Outcomes Framework can be seen at Appendix 3.

5. Finance update

5.1 In 2016/17 as a minimum, Manchester will be required to expand the existing pooled budget for the Better Care Fund (BCF) in line with Department of Health guidelines. At this stage there is no indication whether the scope of the BCF will be expanded for 2016/17, this is likely to be confirmed by Department of Health in December 2015. However, as part of the Greater Manchester Health and Social Care Devolution Agreement there has been a commitment made to move towards a fully pooled budget at locality level over the next few years.

5.2 The intention by commissioners is to develop a single contract for Manchester which will be used to commission to this specification. This will involve building upon the existing BCF partnership agreement but expanding its scope substantially. In line with this ambition, the LLLB finance workstream has completed a 'One Contract' budget scoping exercise, aligned to the four areas within scope as agreed for integration in 2016, namely:

- Intermediate Care and Reablement,
- Integrated Neighbourhood Teams,
- Integrated Access,
- Urgent Care First Response.

5.3 There are several caveats around the work produced to date and these are being worked through with Partners:

- One Team Community budgets do not reflect Primary and Community Mental Health services (apart from IAPT),
- One Team budgets do not reflect DGH activity – work is ongoing to define a list of services in scope with the Providers,
- The CCG's figures are based on 15/16 opening budgets and therefore do not reflect any in year movements in budgets and need to be updated for 2016/17,
- The matrix has not yet been through the necessary governance routes within organisations for final sign off,
- The expanded pool will be larger than the BCF pool of 2015/16, requiring rapid development of a refreshed 'Section 75 Agreement' to govern the use of partners funding, including provision for adequate risk sharing arrangements. Several key risks will need to be managed, including,

- Adequacy and robustness of opening budgets (and transparency about related risks / pressures / opportunities),
- Accountability and governance – a new joint finance committee is proposed to support a new Scheme of Delegation,
- Permitted expenditure definitions need to be agreed upon and financial plans developed accordingly,
- Processes to manage over and under-spends must be agreed, including the amounts to be paid by or returned to partners if these occur.

6. One Contract

6.1 The development of One Contract is being managed under its own work stream, given its importance and complexity. The One Contract Development Group oversees this work reporting into the Locality Plan Steering Group which meets weekly, and has developed a detailed project plan.

6.2 A number of key principles have been agreed:

- Start 'simple' in terms of services to include in the One Contract; in the first instance, phase one integration of community health services and adult social care. This gives commissioners the chance to develop capabilities in one contract development to support more complex commissioning in future years, i.e. inclusion of Primary Care, VCS, and Homecare etc,
- The contract needs to be flexible enough to support different (effective) delivery models in different parts of the city,
- As part of this work commissioners need to develop a collaborative working culture, and identify which capabilities needs to be further supported or developed from scratch to support this new commissioning environment,
- One Contract has to be seen as, and developed as, a means of driving change within the health and social care system. It is the key lever in transforming the community based health system.

6.3 A number of initial challenges have been identified with this work including:-

- The delivery of services on either a registered or resident basis (or both) is unresolved,
- Existing contractual relationships with providers will be disrupted by this work. Given this, stakeholder management will be a key component of this project,
- Lessons learned from previous work to pool budgets in Manchester suggest that the legal work needed to support and ratify One Contract may take a significant length of time,
- Health Care free at point of access and Social Care subject to fairer charging assessments

7. Update on CBA work

7.1 Work has been progressing since the summer to develop a CBA model that can be applied to Health & Social Care Reform programmes. A series of

workshops were held in September / October and since then a model has been developing around the CASS pilot in North Manchester. This emerging model is being tested in the CASS pilot context to, firstly, demonstrate how and why CBA principals can help the emerging programme designs and, secondly, test that it is able to measure an agreed and consistent view on impact across a range of stakeholders.

7.2 The model will help commissioners better understand the costs of delivery; the investment requirements against these costs; the periods of payback and return on investment; and an opportunity to discuss specific parts of the model more clearly (i.e. reconciling priorities).

7.3 The model is almost complete for CASS and should then provide the template for other work streams to feed into once their design is complete. An update and walk through of the model can be brought back to this group as requested.

8. Next Steps

8.1 Discussions have commenced between commissioners with regard to the One Team Business case in relation to preparing for the GM Transformation Fund. This will sit alongside the development of the Service Specification. It is envisaged that work being completed under the CBA is fundamental in developing the business case for change.

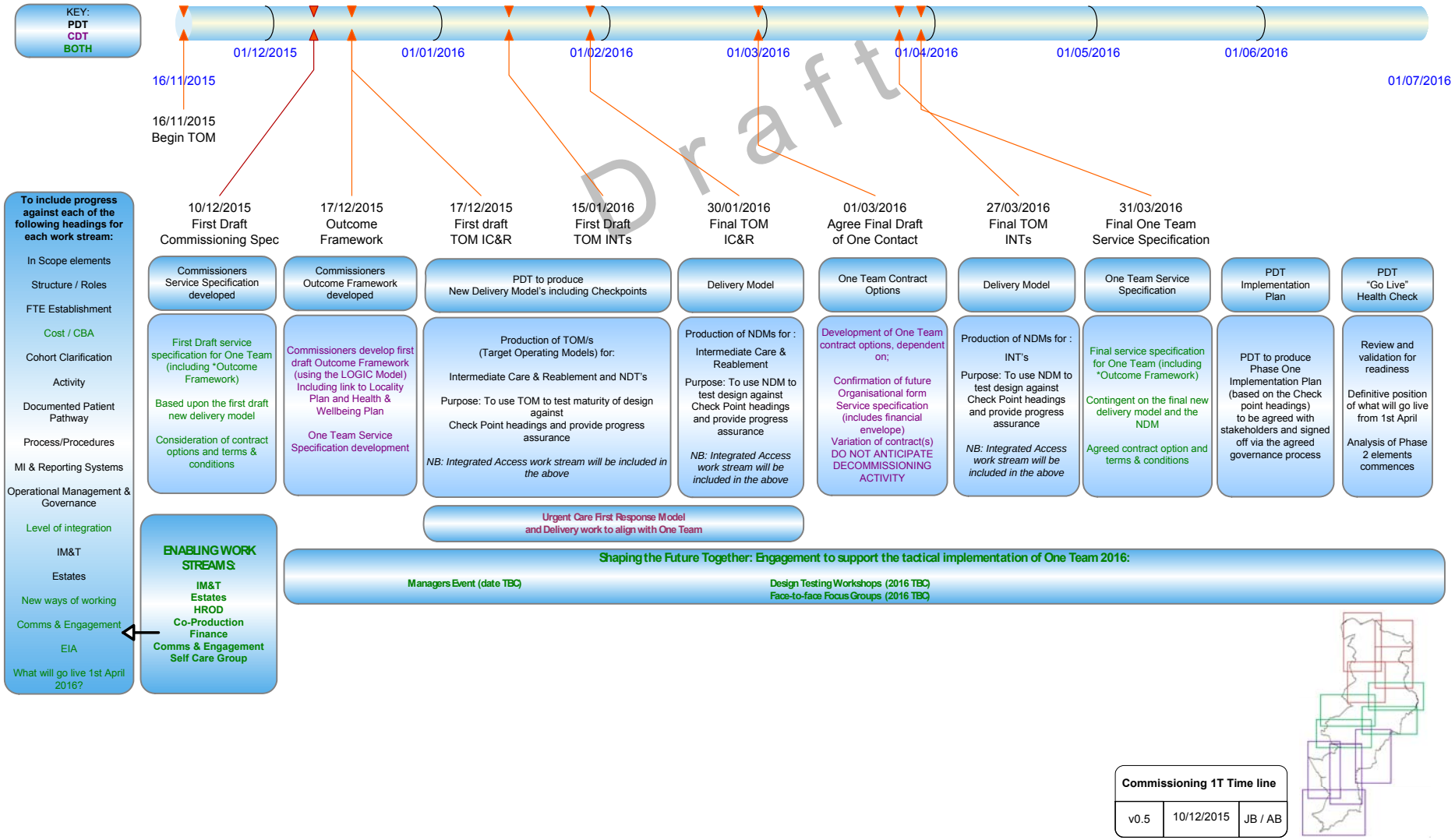
8.2 The LLLB CWLG is currently undertaking a piece of work to re-plan first phase implementation timescales for 2016. This work is being undertaken in light of capacity issues across the system and the need to link up enabling workstreams more effectively.

8.3 All three commissioning products outlined in section 1.1 will be impacted by this replanning exercise, in that their delivery timescales will be realigned to the revised implementation schedule.

8.4 The CPT will have a specific focus on the following key issues over the next few weeks:

- Development of a more detailed specification for One Team, linking closely with the PDT,
- Contract development,
- Pooled budgets, again with priority for the services the city wants to integrate first; and
- The options for procurement alongside the type of contract needed to ensure resources shift in response to performance metrics relating to reduced demand.

Appendix 1 – One Team Timeline



Appendix 2 – High Level Principles

Principle	Links to One Team strategic aims			
	1. Improving health outcomes	2. Improving service standards	3. Financially sustainable	4. Supporting self reliance
1 **Rebalancing the system** – locally focussed care at home, in the community or in primary care unless there is a good reason why this is not the case.	√	√		√
2 **Right care, right place, right time – first time** - joined-up approach to care, ensuring that people are at the centre of their care planning and receive the least intensive but most effective intervention in the most timely way	√	√		√
3 **Commissioning for outcomes** - service/s will be delivered in an efficient and integrated manner to support the effective achievement of performance indicators and commissioning outcomes. The Service/s will clearly evidence the value they add in achieving outcomes for both citizens and the commissioner which will be high quality and value for money.	√	√	√	√
4 **One system** - community based services which interface with all secondary physical and mental health services in order to ensure flows across the system are effective.		√	√	
5 **Pro-active care and self-reliance** - a system-wide focus on well-being, early intervention and prevention which uses appropriate system tools to promote self care, supports people to be well and independent and to take control of their lives and ultimately reduce demand on services.	√	√	√	√

6	Integrated health and social care services are **safe and of a high quality.**	√	√	√	
7	**A sustainable system –** improved productivity through shared resources, reduced duplication, simplified navigation processes, single customer access points enabling better joint working and creating cost efficiencies.		√	√	√
8	**Multidisciplinary workforce** - multidisciplinary teams structured around 'place' and supported to work within communities to deliver innovative care to meet local needs; linking to and strengthening local assets and networks, including local organisations and the unpaid workforce (e.g. carers, voluntary, community and faith sector).	√	√		√

Appendix 3– One Team Outcomes Framework (draft)

	Objective (Goals)	**Overarching Outcome (measurable difference)**	**Proposed KPIs (what we will measure)**
1	The use of One Team interventions will reduce unnecessary admissions and readmissions will be prevented, reduced or delayed for people in contact with One Team services One Team will reduce the number of A&E attendances in the 12 month period following a person's initial contact with One Team services compared with the previous 12 month period Admissions to permanent residential and nursing care will be prevented/reduced/delayed for	Increased amount of health and social care activity delivered in the community leading to a 20% reduction in spend on acute services by 2020)	Number of people still at home at 30 days and 91 days following discharge from service, Increase access to psychological services/IAPT services Number of events or services delivered in partnership with VCS providers Increase in the numbers of people who move to recovery after treatment Financial impact on community health and social care Reduction in referrals to Psychological therapies Number of avoided admissions to hospital from integrated intermediate care and reablement services Increase in proportion of people with common mental health disorders in employment Number of avoided admissions to hospital from

	Objective (Goals)	Overarching Outcome (measurable difference)	Proposed KPIs (what we will measure)
	people in contact with One Team services People in contact with One Team services will spend less time in hospital People in contact with One Team services will be supported to live in their own home		integrated neighbourhood teams Increase in dementia diagnosis Number of avoided readmissions to hospital from integrated intermediate care and reablement services Number of avoided readmissions to hospital from integrated neighbourhoods Number of avoided admissions to residential care Number of avoided admissions to nursing care Number of bed days saved Number of delayed discharges Number % of referrals made to non-NHS/LA provider organisations to provide home/community based support Numbers of local community groups/organisations delivering services/groups support within same building as One Team
2	The needs of carers are identified and supported to enable them to carry on their caring role Service (and referral pathway) information is up-to-date, good quality and easily accessible to citizen/patients and their carers	Decrease in carer breakdown	Number of carers identified Number of carers referred for assessment Numbers of carers given information and signposting. Numbers of carers offered a services (all above collected by MCC) E.g. One team referral pathways in place/regularly reviewed PREM Referral audit Number of referrals accepted/declined/signposted elsewhere

	Objective (Goals)	Overarching Outcome (measurable difference)	Proposed KPIs (what we will measure)
3	Citizens/Patients and their carers will have a positive experience of good quality care and support delivered by One Team services The person/patient is in control of the assessment and planning process for their care and support Carers and family members are involved in the care assessment and planning process People will receive care that is well coordinated and improves their quality of life People will be able to access One Team services within appropriate waiting times People approaching end-of-life will have a personalised Advanced care plan People are supported to die in their place of choice Improving the experience of care for adults with mental illness	Increase in citizen/patient and carer satisfaction	Patient experience: Patient/citizen feedback questionnaire All Patient/carers given satisfaction questionnaire. Referrer satisfaction questionnaires. Staff surveys and reports. Audit response and produce report The % of patients referred to the service who have their experience of using that service formally captured using commissioner agreed tools, including the Friends and Family Test (<=15%) PROM / PREM % of patients having a crisis plan built into their individual care plan so that patients and their carers know what to do and who to contact in an emergency. The % of patients who have a care plan which includes individualised support for their health, social and emotional needs, appropriate to their preferences, to maximise independence and reduce social isolation. The percentage of patients approaching end-of-life who have a personalised care plan (to include either a Preferred Priorities of Care document or an Advanced Care Plan). Increase in numbers of people dying at home Increase in people feeling independent and able to manage their long-term conditions in their own home Increase in health-related quality of life for people with LTC and their carers Increased number percentage of staff reporting

	Objective (Goals)	Overarching Outcome (measurable difference)	Proposed KPIs (what we will measure)
			that they have sufficient information about what existing community based support (non-treatment based, locally provided/organised support, including volunteering) is available to support them to deliver person-centred care (through staff survey)
4	Staff will receive the relevant support, training and supervision to become competent practitioners in an integrated team All Staff within One Team to receive training in community based assets and an asset based community development approach to assessment and support links to the 'Community of Connected Individual. Staff will develop knowledge, skills and experience to deliver a good quality service, in line with their professional bodies and organisation's mandatory training One Team services will facilitate innovative and person centred approaches Integrated teams will have a	Increase in staff working in multidisciplinary teams in the community to improve service delivery, practice and innovation.	Number of health and care professionals working as part of a multi disciplinary team Number of multidisciplinary assessments completed Number of trusted handovers (discharges) completed Number of MDTs Cases allocated to appropriate worker (or those that needed to be re-allocated) Increase number of patents receiving appropriate care through an integrated team Number of health and care professionals working as part of an integrated team Increase in people receiving a multidisciplinary assessment using an appropriately validated tool Reduction in safety incidents linked to uncoordinated multidisciplinary working Biannual staff survey *KPI re measuring behaviour/culture change TBD* Possible innovation work stream Validated case studies for innovative working Sharing good practice Organisational Development: HR policies

	Objective (Goals)	Overarching Outcome (measurable difference)	Proposed KPIs (what we will measure)
	shared strategy, vision and strong leadership that sets out the values that need to be promoted across all agencies Staff use a shared language and identify as One Team rather than colleagues from different professions/services One Team services are delivered in a way that understands the impact of practices and decisions on people with different protected characteristics and thereby plan services more effectively and equitably. To have an integrated mental health professional within One Team, who is able to support people, recovering from an SMI, in maximising their concordance with prescribed medications; to actively liaise between the locality team and specialist MH services to ensure support and care is immediately offered if a person's MH needs increase or MH deteriorates.		Job descriptions to reference quality Audit of care plans, job consultations, appraisals Possibly measured through quality assurance, audit of care plans Number of people receiving care from an integrated team Number of referrals accepted Number of referrals dealt with within agreed response times Number of referrals dealt with outside of agreed response times Number of Equality Impact Assessments Number of people with mental illness who die prematurely

	Objective (Goals)	**Overarching Outcome (measurable difference)**	**Proposed KPIs (what we will measure)**
5	One Team services will proactively support the early identification of long term conditions People in contact with One Team with mental health illness and long term conditions will have an enhanced quality of life and support will help people to recover People with mental illness recover and have improved outcomes in:- Symptom reduction Improved physical health Improved quality of life linked to: • Employment • Education • Occupation • Better relationships • Part of their communities To ensure that for people with severe and enduring mental health problems their physical health care needs are understood by regular monitoring and access to appropriate physical healthcare interventions so people can experience good physical health,	Increase in early identification of long term conditions including mental illness	Number of dementia screening tools completed Number of frailty Assessments completed Add references to pathways for other conditions e.g. COPD, cancer, mental health conditions Number of referrals received from community based/VCS organisations Number of referrals received from community based/VCS organisations that result in the early diagnosis of a long term condition Increase in specialist services being delivered in the community Numbers accessing to psychological therapy/IAPT services (data for BME and older than 65 years also required) Increase in numbers in the proportion of referrals to IAPT that move to recovery at the end of treatment. (data for BME and older than 65 years also required) Numbers of people who wait no longer than 18 weeks for IAPT services Numbers of people who access community MH services by people from BME groups Numbers of people with common mental health disorders and mental illness, and LTC's in employment Number of people with a dementia diagnoses Measure of effectiveness of post (dementia)diagnosis care in sustaining independence and improving quality of life

	Objective (Goals)	Overarching Outcome (measurable difference)	Proposed KPIs (what we will measure)
	and to administer anti-psychotic depot injections To offer pro-active and needs based support for people recovering from severe and enduring mental health problems (SMI)(this will be an element of the MHIP Rehabilitation from psychotic illness, and longer term care pathway) to help people remain in stable housing, employment or occupation, be part of /engaged in their communities		People with dementia prescribed anti-psychotic medication Numbers of people with severe mental illness who have received a list of physical checks More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. Most initial episodes of psychosis occur between early adolescence and age 25 but the standard applies to people of all ages in line with NICE guidance.
6	People receiving One Team Services are supported to develop or re-gain skills to enable them to live as independently as possible	Increase in numbers of people reporting an improvement in level of independence	Number of validated frailty tools completed Increase in people feeling independent and able to manage their LTCs in their own homes based on validated tool scores Increase in proportion of people reporting as self caring – (could be measured after interventions by questionnaire as in reablement now) Patients offered Patient Activated Measure Tool (PAM) at start and end of intervention Number of evaluation forms completed The percentage of patients asked reporting that they are able to live more independently following the interventions of the service Increase percentage of people reporting increase in independence who have had existing community based support built into care plans

	Objective (Goals)	**Overarching Outcome (measurable difference)**	**Proposed KPIs (what we will measure)**
7	One Team services will support people and their carers to build awareness and understanding of their conditions and support them to take responsibility for their health and care needs	Increase in number of citizens/patients and carers able/supported to self care	Increase in proportion of people reporting as self caring Additional measures to be included from Wellbeing service work
8	Public health services linked to One Team will support and influence culture and behaviour change at both individual and community levels (building capacity at a community level to be self-sustaining). By: • Improving knowledge, skills and behaviour in relation to health and wellbeing • By measuring impact on mental health and physical health • By enabling partner organisations to develop health promotion programmes • By evaluating staff training programmes with some evidence of changes in workplace approaches e.g. enabling self care One Team services are delivered	Reduction in health inequalities and variations in levels of wellbeing across the city.	Number of care plans including an element of existing community based support (non-treatment based, locally provided/organised support, including volunteering) Number of people reporting that they are engaging in an element of existing community based support (non-treatment based, locally provided/organised support, including volunteering) Equality Impact Assessments *(Assuming Wellbeing service is included in scope for phase 1)*

	Objective (Goals)	Overarching Outcome (measurable difference)	Proposed KPIs (what we will measure)
	in a way that considers the impact of practices and decisions on people with different protected characteristics and thereby plan services more effectively and equitably.		