Manchester City Council
Report for Information

Report to: Health Scrutiny Committee - 5 September 2017

Subject: New Models of Care

Report of: Michael McCourt, Interim Chief Executive, Manchester Providers
Dr Carolyn Kus, Executive Director, Strategic Commissioning

Summary

The process for Manchester Health and Care Commissioning to procure out-of-hospital services has entered the Strategic Dialogue process with Manchester Providers. MHCC have set out the expectation that in year one, starting April 2018, the priorities for go live are directly provided Adult Social Care Services, Primary Care and Community Health Services. In order to deliver the priority outcomes for Manchester – as per the Locality Plan, Investment Agreements, and the Strategic Dialogues process – an integrated set of new models of care are required. These will be predominantly neighbourhood-based and include entry points to services, the development of integrated neighbourhood teams, wellbeing and prevention, and new models of Primary Care.

Recommendations

The Committee is asked to note and comment on the report.

Wards Affected: All

Contact Officers:

Name: Nicky Parker
Position: Director of Adult Social Care Development, Manchester Providers
Telephone: 0161 234 3952
Email: n.parker@manchester.gov.uk

Name: Dr Sohail Munshi
Position: Clinical Director, Manchester Providers
Email: s.munshi@nhs.net

Name: Dr Cordelle Mbeledogu
Position: Consultant in Public Health Medicine
Email: c.mbeledogu@manchester.gov.uk

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. They 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 Greater Manchester Strategic Plan, Taking Charge of Health and Social Care in Greater Manchester

- The Manchester Locality Plan, A Healthier Manchester

1. Introduction

1.1 The Strategic Dialogue process has commenced between Manchester Health and Care Commissioning (MHCC) and the Manchester Providers as part of the journey towards the establishment of the Local Care Organisation (LCO). Commissioners have set out an expectation that in year one, starting April 2018, the services in scope for go live are:

- **Community Health Services**: currently provided by Pennine Acute Hospital Trust (PAHT), Central Manchester Foundation Trust, (CMFT), and University Hospital South Manchester, (UHSM)

- **Primary Care**: Seven day access, Out of Hours, , Standards, and Enhanced Primary Care and Locally Commissioned Services

- **Directly provided services**: including adult social care, reablement and learning disabilities services currently provided by MCC.

1.2 The focus is on the following key priorities:

- **System resilience and demand management** (roll out of integrated approaches out across the city (learning from for example Community Assessment and Support Service in North Manchester) including: Discharge to Assess, Trusted Assessor and Integrated Discharge arrangement across the 3 acute sites, Intermediate Care reablement new offer, Urgent Primary Care Offer)

- **Infrastructure building blocks** for example 12 Integrated Neighbourhood Teams, Social Care reform programmes for home care, and residential and nursing care

- **Transformation funded propositions**. Including High Impact Primary Care (HIPC), Enhanced Reablement Offer, Carers support, Prevention programme, Extra Care, Frailty.

Models of Care

2. Strategic aims

2.1 Health and social care reform is critical to achieving the ambitions for the city, as set out in the Our Manchester Strategy. A progressive and equitable city means people living healthier and more fulfilled lives, with much reduced health inequalities across the city. A liveable and low-carbon city requires resilient places and communities where people can live and age well. A thriving and sustainable city needs a healthier population who are able to work and be more productive in work, with fewer people in poor health not benefitting from economic prosperity.

3. Our Manchester

3.1 The Our Manchester approach is how all partners will deliver the strategic ambitions. This means fundamental changes to how services work. The four principles of Our Manchester are focusing on people and how to make their lives better, genuinely listening, starting from strengths, and building better relationships to work together differently.

3.2 Health and social care reform involves putting people and places of Manchester above organisational interests. It means workforces across the system having different, deeper conversations with each other, and with citizens, to understand what really matters to them and what is most important to their health and well-being.

4. Improving services to improve outcomes

4.1 Improving Health and social care will involve integrating services around people, in particular those who need an integrated service offer. The establishment of the Local Care Organisation will mean the development of new models of care that are based on what people need, not what services have traditionally provided. There will be 12 Integrated Neighbourhood Teams (INTs) established across the city that integrate primary care, mental health, social care and community health. The people of Manchester will have an integrated service offer, with joined-up processes for how they access services, how they are triaged and assessed, and how their care needs are planned once and with their lives and their strengths in mind.

4.2 The INTs will need to work seamlessly alongside other services for people and places. This will involve connecting the INTs to Early Help Hubs, the Multi-Agency Safeguarding Hubs, Work and Skills support and Integrated Neighbourhood Management. People who are being supported by more than one of these programmes need to have a single joined-up experience of support, based primarily on their strengths and what they need as people, families and communities.

4.3 Health and social care reform also involves investing joint resources in new ways of working that will deliver joint outcomes, and save money as demand reduces. There will be investment of transformation funding from a range of sources to reduce demand, measured against specific performance indicators, with evaluation to demonstrate the impact on people's health outcomes and their lives. As demand reduces, some of the savings released can be re-invested. Investment Agreements will underpin this approach to ensure it delivers reform.

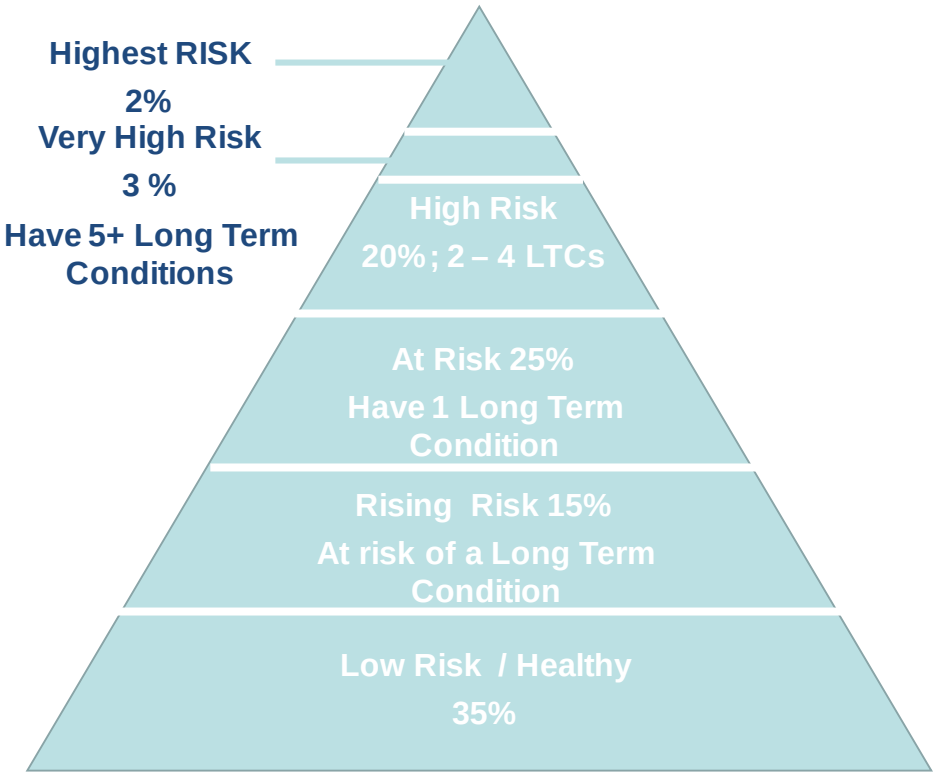
5. Building models of care around people

5.1 The Integrated Neighbourhood Teams within the Local Care Organisation will provide a different offer for citizens based on a judgement of risk. Risk will be considered in the broader sense of demand on future social care and health services. It will be based on a combination of data analytics and the

professional judgement of staff who know people best, in particular, General Practitioners.

5.2 This view of people is the starting point for developing integrated care models. The different level of risks below determine the intensity of support that will be provided:

- Highest risk – High Impact Primary Care (led by GP)
- High risk – Health and Adult Social Care Teams within INTs
    - Frail older people
    - Adults with long term conditions / end of life
    - Adults with complex lives
    - Those with mental health issues, Learning Difficulties and Dementia
    - Children and young people with long term conditions
- Rising risk – Early Help offer including Well Being Officers
- Rising risk / low risk – Community links for health and Neighbourhood Development officers within Prevention



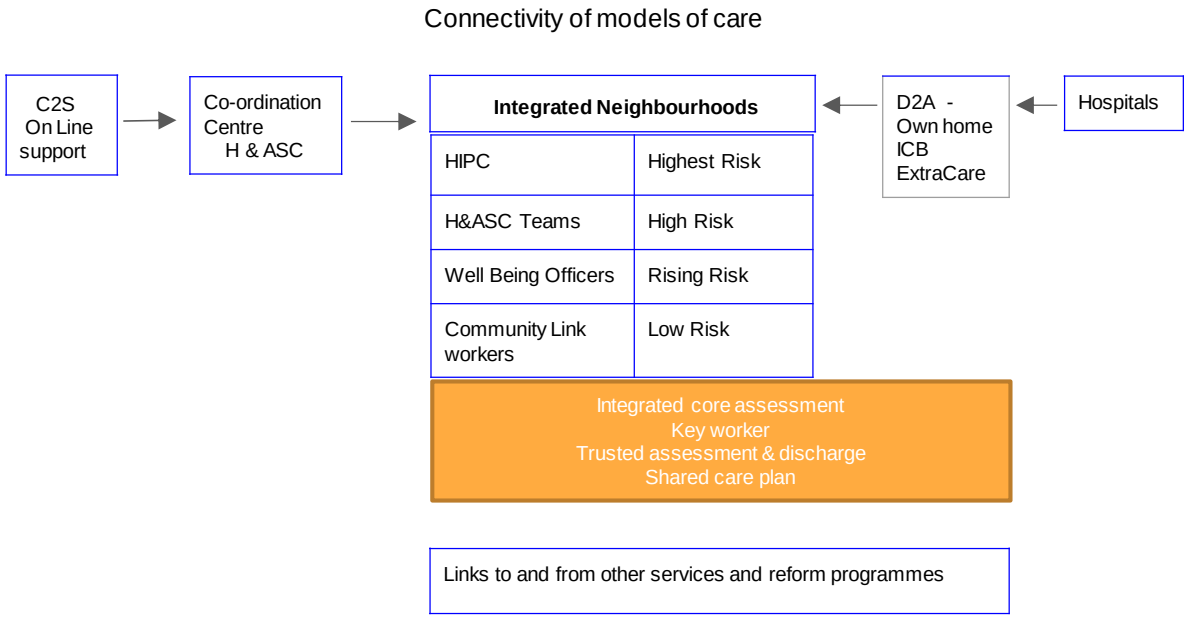
5.3 Some services and programmes will provide support for citizens at different levels of the pyramid, for example reablement includes a standard offer to a targeted group of people, and a more intensive offer for people with more complex needs. The prevention programme is a whole-population approach and not solely focused on those with least risks.

5.4 This approach of integrating services around people will fundamentally change how residents experience services:

- There will be an integrated point of entry into services

- Citizens will have a shared care record so all professionals have a single view, subject to data protection requirements
- Assessments will take the form of strengths-based conversations and not a series of tick-box questions that focus on deficits
- Trusted assessments will be done once so citizens do not have to tell their story to professionals multiple times
- Citizens receiving single, bespoke packages of care with lead workers (for those who need them) who coordinate all the other services in their shared care plan
- Integrated discharge from hospital into community services
- GPs and Primary Care provide leadership and coordination of systems locally to integrate the services needed and understand local populations

5.5 The diagram below demonstrates a high level journey through these systems. Each aspect is explored in turn in more detail below.



5.6 In order to meet these priorities, it will be necessary to deliver a raft of new integrated models of care that are predominantly neighbourhood based and focus on co-ordinating care and managing demand at the front door, the development of integrated neighbourhood teams, the development of a wellbeing and prevention offer and new models of Primary Care.

6. Wellbeing and Prevention

6.1 The Prevention Programme is a core component of the radical upgrade in population health and prevention for Manchester's Local Care Organisation (LCO). The services will be part of the INTs. Within a whole-population approach, there will be information and advice for all, and more targeted services for those identified by assessments in Primary Care and the INTs. The programme will enable integrated neighbourhood teams to take a person and community-centred, asset-based approach to delivering care and

promoting health and wellbeing for the residents of the 12 neighbourhoods served by the INTs.

6.2 The **Community Links for Health** service will connect people who access health and care services with a range of social and community sources of support to enable them to improve their health; sometimes known as "social prescribing". It will be delivered through a team of people who offer one-to-one support, including neighbourhood based community connectors, and more specialist health coaches based in a central hub.

6.3 **Neighbourhood Health and Wellbeing Development** will facilitate locally tailored approaches to achieving the five objectives of the prevention programme that are appropriate for that community. These are to:

- Support residents by strengthening the social determinants of health such as employment and skills, finance, housing and social connectedness
- Support the adoption of healthy lifestyle choices across the life course such as physical activity, nutrition, smoking cessation and emotional wellbeing
- Improve the quality of life, health outcomes and life expectancy of people with long-term conditions by identifying long-term conditions early (this is known as 'finding the missing thousands'), and facilitating a proactive approach to management of long-term conditions.
- 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.

6.4 Twelve Health Development Coordinators (HDCs) will be recruited, with one based in each of the integrated neighbourhood team. Their role will be to develop and implement plans with neighbourhood teams, voluntary and community sector organisations and communities.

7. Early Help

7.1. The model of Early Help for adults will virtually integrate with the existing offer of Early Help for children and families, and other people and place-based reforms to services. It will involve 24 Well-Being Officers established in hubs to offer earlier intervention to prevent citizen's health and social needs from escalating and therefore reducing downstream demand for high cost home and residential care and specialist support. Two delivery models will be tested. In one locality the Wellbeing Officers will be co-located and part of the integrated neighbourhood teams, in another locality the team will sit as a locality team working virtually with the Children & Families Early Help hub (a larger building would be required to co-locate both teams).

7.2. This approach targets 'rising risk' and people with complex needs who do not meet the thresholds for existing services or 'fit' into existing models of service delivery. Citizens will be identified by a range of services and professionals including GPs. This Early Help approach will also support citizens to take more responsibility for their health and wellbeing.

7.3. The new model will take the Our Manchester strength / asset based approach, having conversations with individuals and their families to identify and respond to what matters. The workforce will develop personalised health & social care plans for people using a wellbeing approach. These wellbeing plans will focus around self-management and self-determination. The Hubs will be developed alongside the Prevention Programme, reforms to Entry Points, reaching into Primary Care and the Voluntary and Community Sector.

7.4. The new Early Help offer for adults will also include closer working with specialist services such as drugs and alcohol, specialist health workers, domestic violence and advice workers, homelessness and primary care mental health teams, alongside other key partners including police, fire, ambulance and housing providers. This partnership working will identify people at risk, contributing to the reduction of any unnecessary hospital admissions, positively supporting citizens and reducing cost across the whole system.

8. Co-ordination of services

8.1 There are currently over 100 access points into the community health and social care system, through GP practices, community health clinics and the Council's Contact Centre. The data held in each system is not easily viewed as one care record and consequently care is not co-ordinated across the system. A major piece of work is underway to streamline and simplify the access points with the aim of developing a single multi-platform system, of telephony, online, email, social media systems to ensure information and data is captured once, viewable by appropriate workforces, so co-ordinated activity can follow.

8.2 Work is underway to develop an online Citizen's Portal. This will support the scaling up of individual and personal budgets with online self-assessment, an online personal record where people can see their support plan, an electronic marketplace to purchase goods, online advice and information and a virtual wallet where people can manage their personal budgets. Online self-assessments for carers has successfully launched and this will be scaled up for everyone by the end of December 2017.

8.3 This will be integrated into the new online community health and care records systems used by staff (for example EMIS for community health) with the aim that everything will eventually be viewable through one single Manchester Care Record at the coordination centre. This will be integrated using an ICT platform over time with Ambulance (NWAS) and Emergency Department (ED) settings and subject to further agreement, with Primary Care.

8.4 The multitude of phone lines and call centres will be reviewed with the aim of streamlining some or all into 3 locality based co-ordination centres, staffed with new enhanced care co-ordinators who will co-ordinate and deploy care across the LCO including equipment, District Nurses and Reablement. This will be piloted in North Manchester to begin with across the hospital ED,

GotoDoc, Community Health and Adult Social Care**.** This would comply with the information and advice requirement under the Care Act 2014.

9. Integrated Neighbourhood Teams (INTs)

9.1 INTs are made up of workforces across adult health and social care and will be co-located across 12 neighbourhood teams. Each team will be managed on a day to day operational basis by a single line manager from any one of the partner organisations and additionally, staff will receive professional / clinical supervision as part of a duty to maintain registration to practice which maybe from a different person. Each neighbourhood leadership team will be led by Primary Care (GP) and will promote strategic development through working with partners beyond the integrated health and social care teams including, but not limited to, mental health, VSCE pharmacists, NWAS and eventually, other Care Providers. There will be an emphasis on prevention, supported self-management, an asset based approach and supporting people to stay closer to home.

9.2 The INTs will work from the principles of 'one team' in the place, rather than being led by professional or organisational interests. They will use new ways of working including single trusted assessment, integrated support and care plans, person-centred care using the Our Manchester strength-based approach. An integrated core assessment has already been developed to assess the needs of those who are eligible with urgent care needs, which informs a single shared support plan, avoiding duplication and multiple hand-offs.

9.3 The INTs will work together with people and place-based services (including public service reform activity in Early Help Hubs, employment and skills support and Integrated Neighbourhood Management) to integrate care for individuals, families and communities where more than one of these programmes is involved.

10. Reablement

10.1 Reablement, delivered currently by MCC staff, is an evidence based approach to maximise people's ability to return to their optimum, stable level of independence, with the lowest appropriate level of ongoing support. It is delivered 7 days a week between 7am and 10pm.
Its aims to:

- Prevent non elective admissions and readmissions to hospital
- Prevent admission into institutional care because of deteriorating health and care needs
- Improve the quality of life of service users

10.2 Over the last 18 months, Reablement has been integrated with Intermediate Care Services in North Manchester successfully under the single line management of a member of staff from Pennine Acute (PAHT). The new delivery model has been evaluated and proven better outcomes for people and a cost saving to the system. It is time now to roll this new model out

across the whole City. The evaluation demonstrated a good return on investment. There is insufficient capacity to meet demand, particularly from hospitals in discharging patients safely.

10.3 The aim is to increase the capacity by recruiting an additional 60 workers across the city to provide targeted support where it will be most effective. The staff will be deployed flexibly where demand is highest following the integrated model developed in North Manchester. An investment bid to the Greater Manchester Transformation Fund is in train to fund the expansion of reablement, complex care reablement, and discharge to assess.

11. Complex care reablement

11.1 The Reablement service has been a significant driver in increasing the numbers of citizens receiving care at home, and facilitating early supported discharge from hospitals. However there are a number of people for whom the service cannot meet their needs at home, Providers feel unable, after assessment, to be able to take on some particularly complex individuals, or request significant increased levels of staffing to meet their needs. This significantly increases cost to both citizens (where applicable) and the adult social care budget. Usually these are individuals who do not meet continuing healthcare criteria.

11.2 Although this client group represents a small cohort, they use exceedingly disproportionate and growing amounts of ASC spend. This time includes Reablement workers and Social workers who spend many hours attending case conferences / safeguarding Multi-Disciplinary Team (MDT) meetings with providers without achieving a safe move on care pathway. Indeed there is clear evidence that this is a city wide issue and that a new transformational approach to supporting complex individuals is required.

11.3 A new offer is being developed across the city met by a small team of 12 enhanced reablement officers. They will join the existing Short Term Intervention Team that supports adults with Learning Disabilities, and be the start of developing a more comprehensive offer keep people with complex lives safe and well at home. Staff will work with individuals to support them to manage their daily living. The offer will extend past the traditional up to 6 weeks with the objective to prepare the individuals for transfer to long term home care with the behaviour and motivation that providers can manage. The emergence of the high impact primary care (HIPC) care model for the top 2% of at risk people will also provide longer term care and support for the cohort managed by complex reablement. As this type of reablement role is different from the core offer, staff will receive additional training and support.

12. Transfer to recovery (working title Journey Home)

12.1 The need for safe, effective and timely transfer from hospital is critical in ensuring patients' ability to maximise their independence and to support urgent care system flow and performance. Delayed transfers of care (DTOCs)

have become a key challenge to system performance and resolving problems with DTOCs has become an increasingly high priority locally and nationally.

12.2 The reforms set out here to create new models of care will reduce DTOC levels across the city and this will also respond to the DH / LGA agenda of implementing High Impact Change models of care.

12.3 The focus of the Transfer to Recovery model is to significantly expand the current assessment capacity of the domiciliary reablement and intermediate care services to enable management of the potential caseload of up to 100 patients at any one time – this will be almost a doubling of the current intermediate care home pathway caseloads and 30% increase in reablement caseloads.

12.4 Individuals would be assessed within 24 hours of a referral from hospital. The expansion will support an assessment within 4 hours of notification that a person is Medically Optimised for Transfer and/or has a Trusted Assessment in place, from a recognised Trusted Assessor in a hospital setting. Assessments will take place in the person's own home in line with the evidence that undertaking schemes for recovery and rehabilitation are far more effective in a person's own home, than in a transitional residential or nursing home bed.

12.5 This model requires expansion of a range of roles in health and social care to deliver a seven day service, 8am to 10pm Social Work.

13. Primary Care Transformation

13.1 Primary Medical Care is the foundation of the NHS, and is delivered across Manchester by 90 GP Practices. Of all the contacts within the NHS, 90% are handled by Primary Medical Care, as such the performance of Primary Medical Care is of critical importance to the wider health and social care system.

13.2 Greater Manchester Primary Care Reform programme is the GM response to the national "General Practice Five Year Forward View", with four domains:

- GP Resilience
- Improving Access
- Workforce
- Estates

13.3 Within Manchester this work has been spearheaded by Manchester Primary Care Partnership, the tri-federation of GP Federations in Manchester.

13.4 To complement and enhance the delivery of GM objectives, the Federation has set clear local priorities across a programme of change:

- Provision of Primary Care Services across multiple practices for a neighbourhood, such as GP appointments at evenings and weekends
- Neighbourhood clinical leadership
- Provision of population coverage for Locally Commissioned Services

- Delivering an interface for the wider system with Primary Care, enabling progress around new structures such as the LCO to be considered by practices
- Providing physician input into development of new models of care

13.5 The GP Federations in Manchester are striving to support General Practice through the changing landscape, enabling sound decision making and securing ongoing sustainability for Primary Medical Care across the city.

13.6 In addition, new models of care around frailty and people with high impact needs are also required.

14. High Impact Primary Care

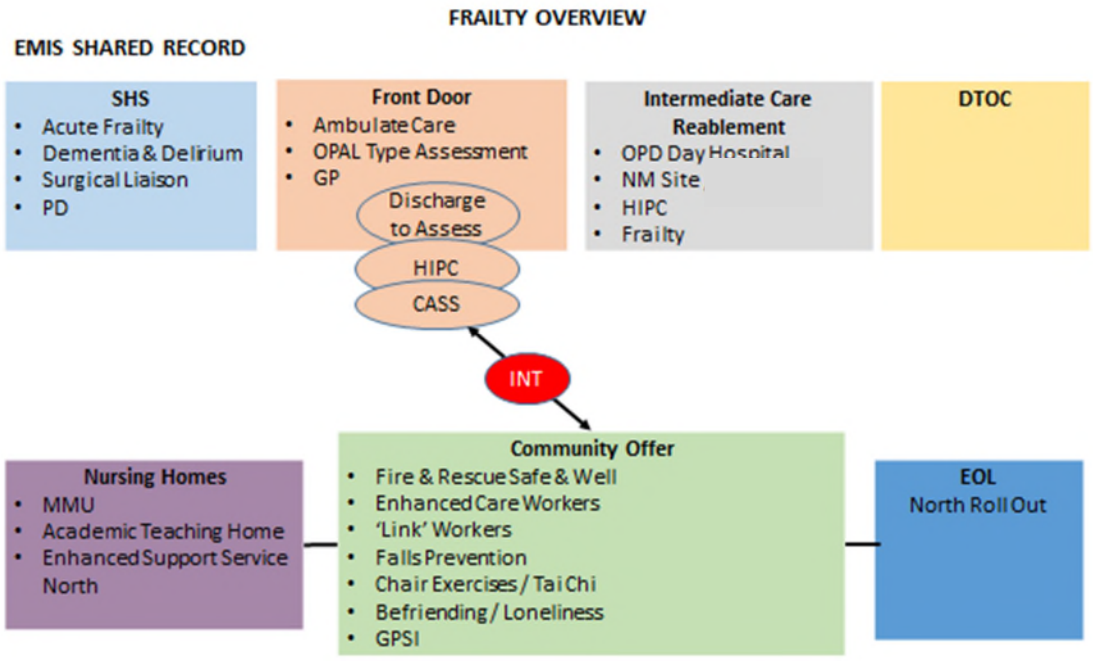
14.1 High Impact Primary Care (HIPC) will be a new dedicated team and service offer for people in Manchester who have the most complex health and care needs who are currently frequent users of hospital based services. The HIPC team will be setup and piloted as 3 teams in 3 neighbourhood areas in the city to determine how efficient and effective the model is at improving the health and wellbeing of people with a high level of health and care needs, and at reducing their reliance on hospital based services. The core HIPC team will be led by a GP working with a Nurse Practitioner, Social Worker, Community Connector and Pharmacy practitioner. The HIPC team will also build links and work in partnership with local primary care services, the local Integrated Neighbourhood Team, specialist mental health and other local services and community groups.

14.2 A small percentage of the Manchester population are very vulnerable and have complex health and social care needs, finding it difficult to navigate and access the standard healthcare system offered across General Practice, community nursing and social care. People HIPC should typically be helpful for will have multiple long term conditions that they are struggling to manage, together with mental health problems and / or other social issues. Some people end up using hospital based services, such as A&E, more frequently than expected as they find it difficult to keep themselves healthy, safe and well at home. The HIPC service are targeting approximately 2% of Manchester's population who are thought to be the most vulnerable in terms of their health and care needs, and who should benefit from a highly targeted proactive, flexible and integrated service.

15. Frailty

15.1 A multi-disciplinary team approach will be developed to integrate health and social care services for frail people. This will be led by community organisations including Fire and Rescue, working in partnership with Primary Care. There will be formal links into the Integrated Neighbourhood Teams as well as specialist hospital services, which will create better community linkages in line with the national five year forward view for frail people. A focus on loneliness and isolation and the prevention of falls will be key components

of the re-design. The diagram below gives a brief schematic overview of some of the services which will link together in these pathways.



16. Commissioned Services

16.1 Whilst the priorities for year 1 are directly provided social care, reablement and learning disabilities services, work has also begun to commission new models of care for homecare, residential and nursing services. This is in preparation for these coming on line in 2019/20. An update appears elsewhere on the agenda for this meeting. Other work is underway to develop new models of care for carers support and Extracare housing

17. Carers support

17.1 The Manchester Carers Strategy is currently being reviewed and the role of carer support in delivering the goals of the Manchester Locality Plan will be strengthened. This will be in line with the Greater Manchester Memorandum of Understanding for Carers. Assessments of those who are carers and those who are cared for need to be integrated and streamlined. The presence of an informal carer must not negate the need for effective support planning, and the potential social isolation of carers and their training needs must be addressed. An effective range of planned and emergency support systems for carers is central to the goal of care delivered closer to home.

17.2 The 'universal' carer support offer co-produced with the local VCS will be realigned and strengthened in line with the 12 one-team neighbourhoods, the role of GPs in identifying and supporting the health of carers will be reinforced and the Community Links for Health Service will connect Carers to sources of local support.

17.3 The 'targeted' carer support offer provided by specialist care management staff will continue to support carers through the provision of Carer's Personal Budgets. However many carers are themselves elderly or vulnerable. Staff will be asked to undertake a more active case finding role to identify and champion the needs of carers where there is the highest risk of a breakdown in care arrangements, and to plan for potential emergencies. Additional resources will be made available in the form of a Carers Emergency Sitting & Respite Service funded via the Greater Manchester Transformation Fund. The resilience of carers will be enhanced by an additional CCG investment in the personalised training of carers to equip them for the many complex caring tasks that may be encompassed within the caring role.

18. Extra Care housing

18.1 This Committee has previously received information about the new Extra Care model of housing. Since the beginning of the year, Village 135 has opened and brings the current total of provision to 7 schemes citywide. Village 135 offers a modern approach to retirement living for older people, comprising of 135 two bedroom apartment, offering spacious accommodation together with onsite care provision. A new feature of Extra Care Housing (as well as Sheltered Housing) is the introduction of Neighbourhood Apartments within the schemes; these are furnished apartments within schemes leased to MCC to provide a faster discharge from hospital offer as well as provide an alternative to hospital or residential care for older people who may need extra support living in the community. Within Village 135, 5 Neighbourhood Apartments have been leased to MCC to develop this new model of provision which will deliver:

- A reduction in people delayed leaving hospital care
- A deflection in people admitted to residential care
- Improved outcomes for older people during a period of crisis need

18.2 These apartments are being prepared for use by Manchester citizens and patients and will go live in September. Neighbourhood Apartments are already in existence in some parts of the city:

- 5 within Extra Care schemes (2 North, 2 South plus 5 Village 135)
- 6 within Sheltered Housing (5 in North and 1 in Central)

18.3 The maximum duration of stay is approximately 6 weeks. A new referral process, detailed tracker and new Placement Co-ordinator is now in place to generate referrals from health and care professionals.

19. Programme and implementation

19.1 There is a full programme of work to support the LCO to begin to run services on the 1st April 2018, of which the New Models of Care work is a critical part. Manchester Providers are developing a service strategy that covers the next three years and working out how we put management arrangements in place so that teams at neighbourhood level are working together effectively from April 2018.

19.2 As Members will know, the LCO is also in a procurement process to support the award of the 10 year contract. Manchester Providers are producing a business case which will need to demonstrate how health and care services are sustainable over the contract term and how the finances are sustainable. The first step in doing this is to share information about the services which will come under LCO management in April 2018 (refer to previous section) and to undertake a baselining or due diligence exercise. This means that all partners, including commissioners, will share the information on services, people, reviews (CQC, Ofsted), finances, buildings and IT to support the development of the business case. A key output of this work is a shared sense of the range of risks we are actively managing across the city in terms of care provided in out of hospital settings and the mitigations we agree to put in place around this.

19.3 Work is also currently underway to establish the governance for the LCO which will include the establishment of the LCO Board which has all four partners on it (GP federations, MCC, Manchester Mental Health NHS Trust and Central Manchester Foundation NHS Trust as the lead bidder). The LCO is planning to begin operating in 'shadow form' from October 2017. The responsibility for risk and delivery will remain with the original organisation during this period, but it will enable the LCO to work through and test the governance and operational arrangements. The LCO will officially start in April 2018 with the first services working as part of the organisation and an agreed framework in place for the transfer of other services across the period of the contract.

20. Investment

20.1 The emerging 'Investing in Reform' spending plan, covering 2017-21, is set out in the table below, with this period being covered by the GM Transformation Fund Investment Agreement. The recurrent annual cost to mainstream new delivery models is also detailed. The spending plan continues to be subject to revision as individual business cases continue to be refined and a gateway process will continue to be used to test return on investment and progress before the significant schemes become fully scaled up.

Scheme	**2017-21 £'000**	**Recurrent £000**
Business Cases Approved:		
Wellbeing and Prevention	12,573	4,333
Integrated Neighbourhood Teams: Reablement/Discharge 2 Assess	20,715	5,822
Primary Care	3,209	5,000
High Impact Primary Care	10,222	6,162
Carers Support	839	289
Home from Hospital	495	135
Extra care	8,773	3,168
Sub-total	**56,826**	**24,909**
Business Cases Subject to Approval:		
Crisis Response	7,218	2,165

Front door/Care Co-ordination	1,664	466
Frailty (Indicative only)	3,772	1,000
Sub-total	**12,654**	**3,631**
Grand total	**69,480**	**28,450**

20.2 Business cases covering frailty service (expanded service), early help, homecare, assistive technology, mental health and learning disability, some of which are outlined in this paper are still being developed. In addition, further investments within Primary Care also being developed and the schemes approved are non-recurrent at this stage, although a programme of investments will be on-going within an indicative annual resource envelope of £5m.

20.3 The funding for the approve programme includes a combination of investment from the GM transformation fund, CCG investment funding and the Adult Social Care reform grant. As schemes deliver a return on investment by reducing demand, evidenced through the delivery of agreed activity metrics, in addition to releasing savings to close the financial gap, it is intended that a proportion of savings will be reinvested to mainstream the recurrent cost into the commissioner budget. These arrangements will be set out in the forthcoming Manchester Investment Agreement at which point a fuller update on the proposed financial arrangements can be made available for scrutiny.

21. HR and OD impact

21.1 The social care reform programme will demand new way of working for staff which will be delivered through changes in roles, skills and working practices. Health and social care teams have been moving to integrated delivery for some time but the current system reforms will expedite this and drive the expansion of integrated neighbourhood teams across the city. In this context, the HR/OD work programme will address:

- Skills development to deliver new models of care. In particular the skills to deliver a single, strengths-based assessment tool and the responsibility to connect service users with community as well as professional assets. Whilst skills development will largely be a requirement for front-line teams, it will also include roles across the whole system including back office communication roles, for example the Council's contact centre
- Refreshed competencies to support key skills including the Trusted Assessor competency framework
- Greater workforce resilience by reducing agency dependency and expanding the employed workforce
- Clear career pathways and development opportunities, including by embedding the apprenticeship model to enable low skilled staff and carers staff to develop into qualified professional roles. The apprentice strategy will also embrace the local community through ongoing targeted recruitment of local residents and those already in the system within low or unpaid caring roles
- The design of new roles including developing Key Working; specialist advisors for complex cases and the new Care Co-Ordinator role

- Securing the fixed term resources from within the current system to deliver the full reform programme including care specialists; programme management expertise and "enabling" professional advisors

21.2 The HR teams across MCC and the LCO are working together to devise a common organisation development strategy to meet this work plan, with professional resources now working across both teams.

21.3 Significant workforce redesign and development will be required to support delivery of new models of care, and there will also be an associated requirement for HR Business Partner and communication and engagement support to facilitate management of change. It is expected that this support will be provided from the corporate resources being deployed into the LCO or accessed from partner organisations. Management of change will be handled in accordance with the policies of employing organisations and in consultation with trade unions. The primary forum for engagement and consultation with trade unions regarding new models of care will be the LCO Partnership Forum, which was established in June.

22. Summary and next steps

22.1 There is a huge programme of work underway to develop the new models of care under the governance of the Adult Social Care Reform and Primary Care Transformation Programmes. They have been brought together by the emerging LCO into one programme of work that also includes work on the new care models in the Integrated Neighbourhood Teams and the Wellbeing and Prevention programme of work.

22.2 Timescales for next steps include:

- September 2017 – draw down investment in new models of care from Greater Manchester Transformation Fund
- October 2017 to April 2018 – phased implementation of new models of care with this investment, timing varies for the elements set out above
- Until end October 2017 – Business Case process for procurement
- Until end November 2017 – Due Diligence exercises for procurement
- 1 April 2018 – formal launch of the Local Care Organisation, first phase

22.3 In preparation for year 2, work has started on developing new models of care for commissioned services particularly Homecare, Nursing and Residential Care and the Mental Health Transformation Programme. A further paper will come to the Health Scrutiny Committee in January 2018 to highlight developments and progress in the Mental Health Transformation programme.

22.4 The Health Scrutiny Committee is asked to note progress made towards establishing the new models of care in preparation for the start of the shadow form of the LCO this Autumn and the first phase of go live in April 2018.